

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06109									
CERTIFICATE OF DEATH									
06105									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
MARGARET			R. BARRETT			April 20, 1969			9:45AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Colored		2/10/1896		73 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MARYLAND		U.S.A.				WICOMICO			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Salisbury			Deer's Head State Hospital			LABOR			VAB.OUS
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Kent		Chestertown				R.F.D # 3
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
CHARLES FOREMAN			E.L. ZABETH			E.L.A.S			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
			218-30-2232		MRS. ROISE MILLER		CHESTERTOWN, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, right base</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recurrent cerebral thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>18 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (A) (this hospital) attended the deceased from April 22, 1969, to April 20, 1969, that (H) (we) lost saw the deceased alive on April 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (A) (we) (did) (did not) view the body after death.									
22b. SIGNATURE L. V. Maldve, M. D.					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/21/69		
22d. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.					22e. ADDRESS Deer's Head State Hospital, Salisbury,				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/23/1969		23c. NAME OF CEMETERY OR CREMATORY EMMANUEL CEM.		23d. LOCATION (City or Town) (County) (State) R.F.D # 3 Chester Town, Kent, Md.			
24. FUNERAL DIRECTOR Kenneth Miller					ADDRESS Chester Town, Md		25a. REC'D BY REGISTRAR DATE APR 24 1969		25b. REGISTRAR'S SIGNATURE William J. Young

Handwritten notes and markings on the right margin, including a large 'C' and various illegible scribbles.

Handwritten text in the center of the page, possibly a title or a section header, appearing to be 'Handwritten document'.

Handwritten text on the left side of the page, possibly a date or a reference number.

Extensive handwritten notes at the bottom of the page, including a large 'C' and various illegible scribbles.

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Mildred Wainwright BENTHAL						APRIL 24 1969			8:00 AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		Dec 31 - 1931			37 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Virginia		U.S.A.				WILCOMICO Md.						
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury				Peninsula General				Housewife		None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Virginia				Accomack		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Wallops Station				
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last			
George Wainwright						Rebecca Ward						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No				223-36-9910		Henen Benthall - Wallops Station - Va						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY:												
2509 IMMEDIATE CAUSE (a) Induced by Glomerular sclerosis												
DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes mellitus												
DUE TO, OR AS A CONSEQUENCE OF (c) Unknown												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			HOUR A.M. Month Day Year									
			P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION						
						Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1962 to 4-24-69, that (I) (we) last saw the deceased alive on 4-24-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED			
WILBUR R. ELLIS, Jr.									4-26-69			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
WILBUR R. ELLIS, Jr.						MEDICAL CENTER, SALISBURY, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial		4-26-1969		Peninsula Memorial			Newport News Va.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
James H. Fox						APR 30 1969			[Signature]			
Temperanceville, Va.						DATE						

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

061111

CERTIFICATE OF DEATH

06107

1. DECEASED-NAME (Type or print) LULA			First Middle Last DUDROW			2a. DATE OF DEATH Month Day Year APRIL 21 1969			2b. HOUR- 8:45 M		
3. SEX FEMALE			4. RACE white			5. DATE OF BIRTH March 30, 1881			6. AGE (In years last birthday) 88 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Wicomico		
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland			13b. COUNTY Worcester			13c. CITY OR TOWN Ocean City			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 15 th Street			14. FATHER'S NAME First Middle Last unknown Dudrow			15. MOTHER'S MAIDEN NAME First Middle Last unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. 233-72-3821			17. INFORMANT Mrs. E.D. Tilghman			Address see sec. # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 5609 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal obstruction DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 48 hrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION 4-20-69			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-20 , 1969, to 4-21 , 1969, that (I) (we) lost saw the deceased alive on 4-21 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. Kent Carney						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4-21-69		
22d. PHYSICIAN'S NAME (Type) E. Kent Carney M.D.						22e. ADDRESS Medical Center, Salisbury, Md.					
23a. BURIAL, CREMATION, or other disposition (Specify) Burial			23b. DATE 4/23/1969			23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore City Md.		
24. FUNERAL DIRECTOR Hill Funeral Home						ADDRESS Salisbury			25a. REC'D BY REGISTRAR DATE APR 24 1969		
									25b. REGISTRAR'S SIGNATURE [Signature]		

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06112

CERTIFICATE OF DEATH

06108

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 4 Mo			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springhill Sanitarium, Inc.				d. STREET ADDRESS 103 Bryan Ave		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John R Bicking				4. DATE OF DEATH Month April Day 19 Year 1969			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-21-1884	
9. AGE (In years last birthday) yrs. 84		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (County & State, or foreign country) WILMINGTON DEL	
12. CITIZEN OF WHAT COUNTRY U S A				13. FATHER'S NAME JOHN WESLEY BICKING			
14. MOTHER'S MAIDEN NAME LIZZIE LANO SENTMAN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 420-34-9624				17. INFORMANT Address Mrs L R BICKING INC BERLIN MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4339 IMMEDIATE CAUSE (a) Cerebral Thromboses DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12 - , 19 68 to 4-19 , 19 69 that (I) (we) last saw the deceased alive on 4-19-69 , and that death occurred at _____ M, from causes and on the date stated above							
22a. SIGNATURE Wilber R. Ellis, Jr.				22b. DATE SIGNED 4-21-69		22c. PHYSICIAN'S NAME (Type) WILBER R. ELLIS, JR.	
22d. ADDRESS Medical Center, Salisbury Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/22/69		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) BERLIN WOR MD	
24. FUNERAL DIRECTOR Anna A. Burbage Berlin Md				25a. REC'D BY REGISTRAR DATE APR 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06113 CERTIFICATE OF DEATH 06109									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Ernest Joshua Bowden						Month	Day	Year	5:28 A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		Cauc.		2-28-86		83 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Va.		U.S.				Wicomico Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Salisbury			Wicomico Hosp. Home Booth St.						
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md			Wicomico		Salisbury			126 Sester St.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			
Aaron T. Bowden						Mary C. Chandler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			220-32-0703		George Taylor, Chincoteague, Virginia				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Arterio aneurysm</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY			21f. LOCATION				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>3-28, 1969</u> , to <u>4-1, 1969</u> , that (I) (we) last saw the deceased alive on <u>3-31, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
[Signature]					4-1-69				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		4-3-69		Wicomico Memorial Park		Salisbury, Maryland			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Salyer Funeral Home, Chincoteague, Virginia					DATE APR 7 1969		[Signature]		

Book

Wm. J. Chandler

Wm. J. Chandler

Wm. J. Chandler

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Wm. J. Chandler

10-102

Wm. J. Chandler

Wm. J. Chandler

10-102

Wm. J. Chandler

TO HOSPITAL C. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06114 - CERTIFICATE OF DEATH 06110										
1 DECEASED NAME (Type or print) SALLIE			First Middle Last ELIZABETH BRITTINGHAM			2a DATE OF DEATH Month April Day 18 Year 1969		2b HOUR M		
3 SEX Female		4 RACE White		5 DATE OF BIRTH October 12, 1903		6 AGE (in years last birthday) 65 YRS		F UNDER YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WICOMICO Md.				
10 CITY OR TOWN OF DEATH Salisbury			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Peninsula General Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Seamstress		12b KIND OF BUSINESS OR INDUSTRY Shirt Factory		
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before adm: ss on) STATE Maryland			13b COUNTY Wicomico		13c CITY OR TOWN Salisbury		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 205 Tilghman Street	
14 FATHER'S NAME First John Middle T. Last Massey			15 MOTHER'S MAIDEN NAME First Mary Middle Elizabeth Last Elliott							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b SOCIA. SECURITY NO. 220-03-5027T		17 INFORMANT (Daughter) Mrs. Mary C. Linnett, Salisbury, Maryland Address 311 E. Vine St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest (fibrillation) 4/12/3 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) diabetes - congestive failure - post operation										
19a DATE OF OPERATION 4-14-69		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. lip			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State						
22a I certify that (I) (this hospital) attended the deceased from 3-30 , 19 69 , to 4-18 , 19 69 , that (I) (we) last saw the deceased alive on 4-18 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE John T. Bulkeley M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED April 21/1969		
22d PHYSICIAN'S NAME (Type) Dr. John T. Bulkeley				22e ADDRESS Pine Bluff Road, Salisbury, Maryland						
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE April 22, 1969		23c NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland				
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				ADDRESS		25a REC'D BY REGISTRAR APR 23 1969		25b REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

06115

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06111

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN TB 1 Yr. 22 Da.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND COUNTY WICOMICO		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springhill Sanitarium, Inc.						d. STREET ADDRESS GOLF COURSE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rufus		First A.		Middle Brooks		Last		4. DATE OF DEATH Month April Day 23 Year 1969	
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 21, 1890		9. AGE (in years last birthday) 79 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LIGHT HOUSE KEEPER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MATTHEWS VA		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Brooks				14. MOTHER'S MAIDEN NAME MILLIE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WAR I			
16. SOCIAL SECURITY NO.		17. INFORMANT MRS EDWIN HUDSON				Address OCEAN CITY MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thromboses DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4-1, 1969 , to 4-23, 1969 that (I) (we) last saw the deceased alive on 4-23, 1969 and that death occurred at 2 P M, from causes and on the date stated above									
22a. SIGNATURE William R. Ellis				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-25-69			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 4/24/69		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE		23d. LOCATION (City or Town) (County) (State) BALTIMORE MD			
24. FUNERAL DIRECTOR Anne A. Burby Berlin Md.				25a. REC'D BY REGISTRAR DATE APR 28 1969		25b. REGISTRAR'S SIGNATURE William Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-4
45M 1-69

06116		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06116	
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
First Middle Last HAROLD EVANS BROWN				Month Day Year April 30, 1969		7:15AM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH March 8, 1910		6. AGE (In years last birthday) 59 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deer's Head State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Delivery Driver		12b. KIND OF BUSINESS OR INDUSTRY Food Wholesale	
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last Fredrick Hanson Brown		15 MOTHER'S MAIDEN NAME First Middle Last Laura Layfield		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No			
16b. SOCIAL SECURITY NO. 214-10-9694		17. INFORMANT (Wife) Mrs. Nettie E. Brown, Salisbury, Maryland Address P.O. Box 1506					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior Lateral Myocardial Infarction</u> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Thrombotic Occlusion of Left Descending Coronary Artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Recent Recent
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Tracheo Bronchitis, Recent, Cerebral Vascular Accident, Old</u> <u>Arteriosclerotic Heart Disease, Old</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that (A) (this hospital) attended the deceased from <u>August 21, 1968</u> , to <u>April 30, 1969</u> , that (H) (we) last saw the deceased alive on <u>April 30, 1969</u> , and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (not) view the body after death.							
22b. SIGNATURE <u>A. C. Mitchell</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/30/69	
22d. PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M. D.</u>				22e. ADDRESS <u>Deer's Head State Hospital, Salisbury,</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 4, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Church Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Wicomico, Maryland</u>	
24 FUNERAL DIRECTOR ADDRESS <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>MAY 7 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

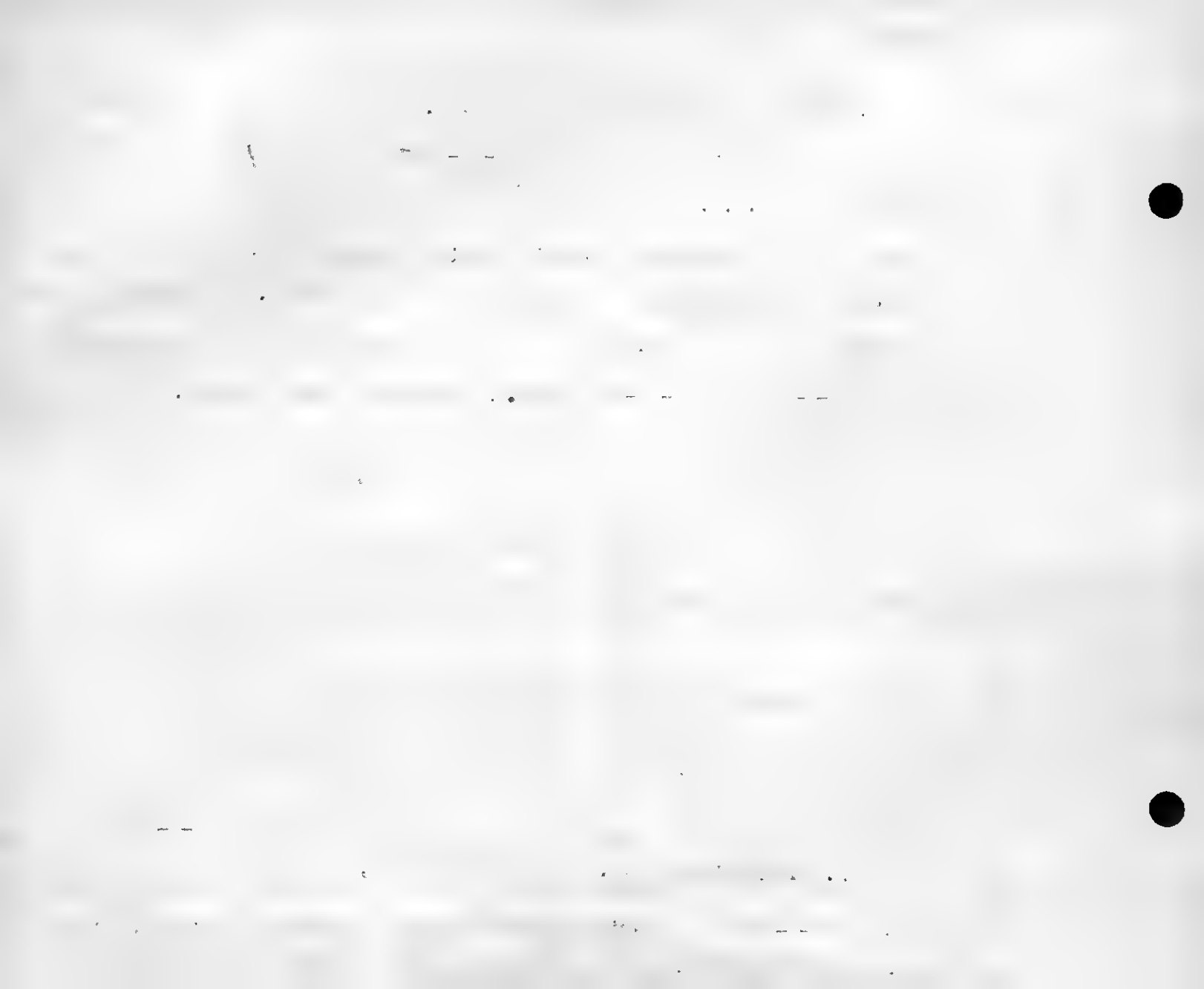
06117

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06113

1. DECEASED-NAME (Type or print) HARVEY THEODORE BROWN, Sr.			2a. DATE OF DEATH Month 4 Day 3 Year 1969			2b. HOUR A.M. 11:07			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10-15-1897		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Retired Farmer		12b. KIND OF BUSINESS OR INDUSTRY Own Farm			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Siloam		13d. INSIDE CITY LIM. 35? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt# 1. Salisbury, Maryland	
14. FATHER'S NAME First Middle Last James Brown			15. MOTHER'S MAIDEN NAME First Middle Last Sarah Warrington						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 220-52-7984		17. INFORMANT Address Mrs. Addie Pearl Brown, See Sec. 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infection of L. x</u> 4-6-69 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Brain aneurysm</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-27-69</u> , 19 <u>69</u> , to <u>4-3-69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-3-69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Carrie Hearn</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-4-1969			
22d. PHYSICIAN'S NAME (Type) Dr. Carrie Hearn M.D.		22e. ADDRESS Salisbury, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-5-1969		23c. NAME OF CEMETERY OR CREMATORY Charity Church Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR ADDRESS Will Funeral Home Salisbury, Maryland				25a. REC'D BY REGISTRAR APR 8 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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06118										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06114																																							
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										Hour																																							
VIRGINIA LEE CANTWELL										APRIL 1 1969										11:40 AM																																							
3. SEX FEMALE										4. RACE WHITE										5. DATE OF BIRTH February 4, 1911										6. AGE (In years last birthday) 58 YRS.										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN										IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Wicomico Md.																													
10. CITY OR TOWN OF DEATH Salisbury										11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Peninsula General										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife & retired										12b. KIND OF BUSINESS OR INDUSTRY Merchant																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Wicomico										13c. CITY OR TOWN Salisbury										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER U.S. Route #13																			
14. FATHER'S NAME First Middle Last Lee B. Ruark										15. MOTHER'S MAIDEN NAME First Middle Last Sarah Jenkins										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no										16b. SOCIAL SECURITY NO										17. INFORMANT (Daughter) Mrs. Violetta M. Elrod, Salisbury, Maryland										Address Rt. 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli										DUE TO, OR AS A CONSEQUENCE OF (b) Lower Extremity & Pelvic Venous Stasis										DUE TO, OR AS A CONSEQUENCE OF (c) BMD, Atrial Fibrillation, Pelvic Emboli										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24h, 48h, 48h																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)										ASCVD, (5) Hemiplegia 2° to Atrial Fib. & CVA in 1967										19a. DATE OF OPERATION 3/30/69										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Saddle Embolus, Distal Aorta										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)										21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 3/30 1969, to 4/1 1969, that (I) (we) saw the deceased alive on 4/1 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Dr. John M. Steffy MD										22c. DATE SIGNED 4/2/69										22d. PHYSICIAN'S NAME (Type) Dr. John M. Steffy										22e. ADDRESS Salisbury, Maryland																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE April 7, 1969										23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park										23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland																													
24. FUNERAL DIRECTOR										ADDRESS HOLLOWAY & COMPANY, SALISBURY, MARYLAND										25a. REC'D BY REGISTRAR APR 8 1969										25b. REGISTRAR'S SIGNATURE																													

06119

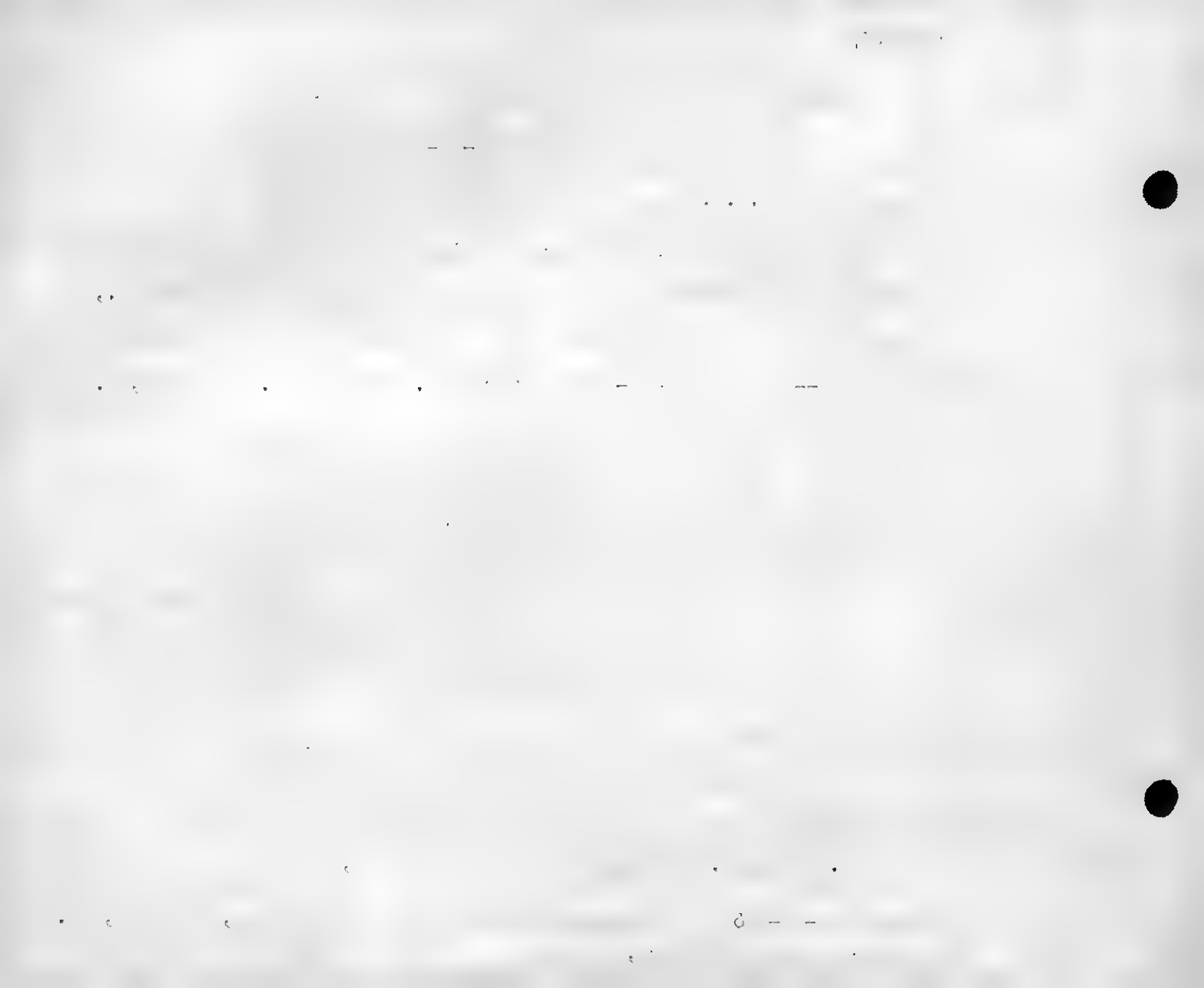
CERTIFICATE OF DEATH

06115

1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b. HOUR		
OLGA			LUCY			CAVANAUGH			Month	Day	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
Female			White			12-13-1905			38 1909 225 M		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Russia			U.S.A.						Wicomico		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital			House Wife			Own Home		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Wicomico			Salisbury			612 Pine Bluff Rd.,		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Dimitri			Kociubenska			Pauline			Grohowska		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No			216-40-4386			Patrick H. Cavaugh, Jr.			Salisbury, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4124 DUE TO, OR AS A CONSEQUENCE OF										Intro cerebral Hem.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										Central Thrombosis	
DUE TO, OR AS A CONSEQUENCE OF										80 hours	
ASCVD.										years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING ETC)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 24 April, 1969, to 28 April, 1969, that (I) (we) last saw the deceased alive on 28 April, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE						DEGREE			22c DATE SIGNED		
Joseph F. Fitzgearld M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			April 28, 1969		
22d. PHYSICIAN'S NAME (Type)						22e ADDRESS					
Dr. Joesph F. Fitzgearld						Salisbury, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			4-30-1969			Wicomico Memorial Park			Salisbury, Wicomico, Md.		
24. FUNERAL DIRECTOR						25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Hill Funeral Home Salisbury, Maryland						MAY 1 1969			Johnas Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
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1

06120

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06116

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MABEL CHASE			2a. DATE OF DEATH Month April Day 30 Year 1969		2b. HOUR 10:15AM
3. SEX Female	4. RACE Colored	5. DATE OF BIRTH MAY 7, 1907		6. AGE (In years last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WICOMICO		12b. KIND OF BUSINESS OR INDUSTRY
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deer's Head State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 721 Washington Street	
14. FATHER'S NAME First Middle Last HENRY E. WARD		15. MOTHER'S MAIDEN NAME First Middle Last SADIE BAYLY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 217-10-8003		17. INFORMANT Address RAYMOND CHASE 721 WASHINGTON ST. 21613	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Embolus 340X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Transverse Myelitis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Large Decubitus Ulcers - - 1 Month					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from April 9, 1969 to April 30, 1969 , that (X) (we) last saw the deceased alive on April 30, 1969 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (X) view the body after death.					
22b. SIGNATURE A. C. Mitchell				22c. DATE SIGNED 4/30/69	
22d. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.				22e. ADDRESS Maryland Deer's Head State Hospital, Salisbury,	
23a. BURIAL, CREMATION, or other disposition BURIAL	23b. DATE 5/5/69	23c. NAME OF CEMETERY OR CREMATORY WAUGH		23d. LOCATION (City or Town) (County) (State) CAMBRIDGE, HOR. MD.	
24. FUNERAL DIRECTOR Frederick C. Blair		ST. CLAIR F. HOME CAMBRIDGE, MD.		25a. REC'D BY REGISTRAR MAY 5 1969	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

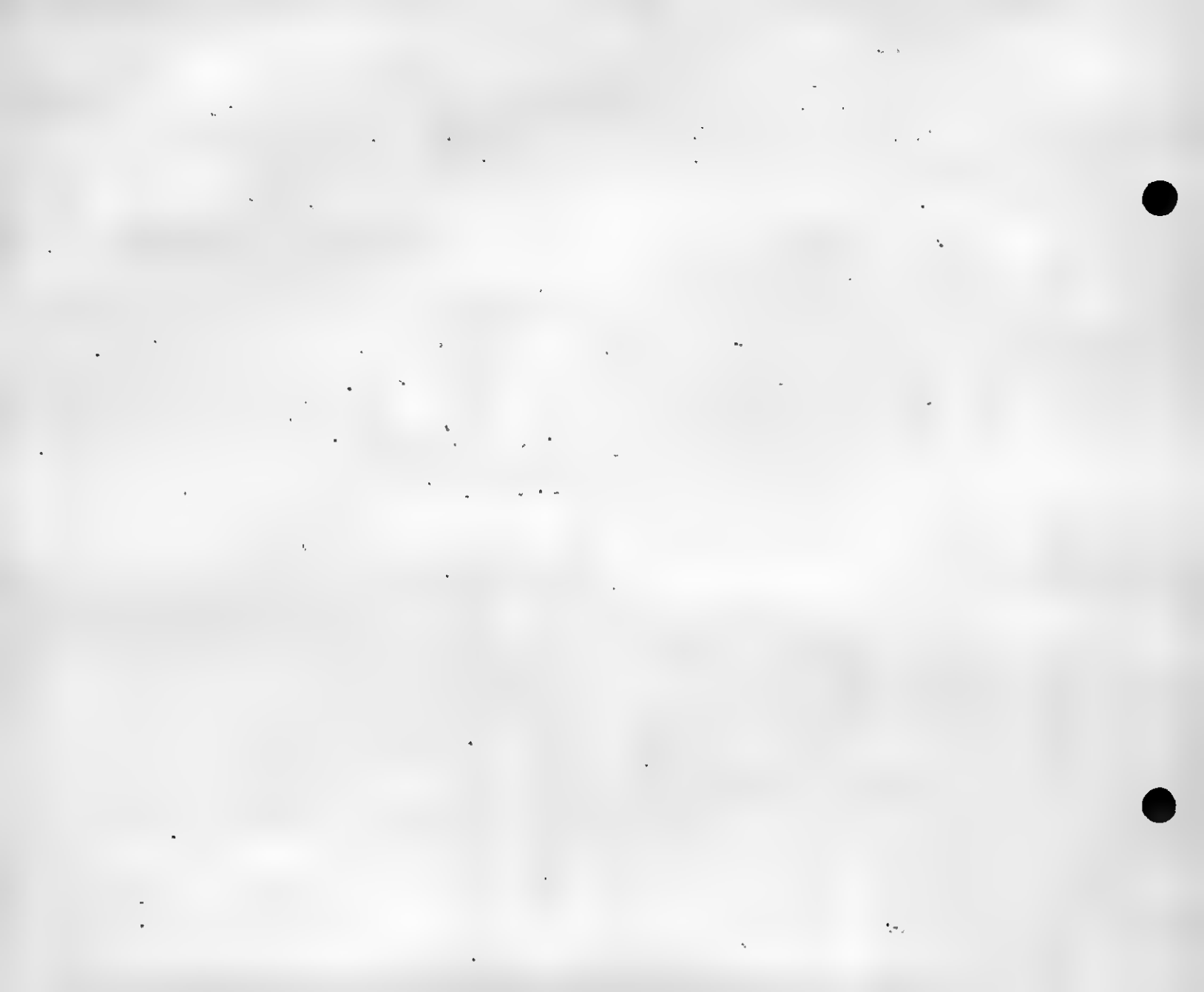
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>06121</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 1 File 412 5/1/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>06117</div>											
1. DECEASED NAME (Type or print) Mary H. Middle COLLINS						2a. DATE OF DEATH Month Day Year APRIL 26, 1969			2b. HOUR AM		
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH 19 JUNE 1893		6 AGE (In years last birthday) 25 YRS		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WICOMICO Md					
10. CITY OR TOWN OF DEATH SALISBURY				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PENINSULA General Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE DELAWARE				13b COUNTY SUSSEX		13c CITY OR TOWN MILLSBORO		13d ASIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER RURAL	
14 FATHER'S NAME First Middle Last NOAH JOSEPH TENDALL				15. MOTHER'S MAIDEN NAME First Middle Last NANCY BAKER							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO				16b SOCIAL SECURITY NO 822-10-8701A		17 INFORMANT Address BEATRICE LYNCH - MILLSBORO, DEL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) poisoning DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 4-26, 1969 , to 4-26, 1969 , that (I) (we) last saw the deceased alive on 4-26, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE Neve W. Todd						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-26-69			
22d. PHYSICIAN'S NAME (Type) NEVINS W. TODD						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 29 APRIL 69		23c. NAME OF CEMETERY OR CREMATORY MILLSBORO CEM.		23d. LOCATION (City or Town) (County) (State) MILLSBORO SUSSEX - DELA.					
24. FUNERAL DIRECTOR Ronald James Millsboro						ADDRESS		25a. RECEIVED BY REGISTRAR APR 29 1969		25b. REGISTRAR'S SIGNATURE Richard S. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <u>John T. Cox</u>						2a. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>69</u>		2b. HOUR <u>9:30 P</u>		M	
3. SEX <u>Male</u>		4 RACE <u>White</u>		5. DATE OF BIRTH <u>3/26/1884</u>		6 AGE (In years last birthday) <u>85</u> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____	
7a. BIRTHPLACE (State or foreign country) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Wicomico</u> Md					
1d. CITY OR TOWN OF DEATH <u>Tyaskin</u>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>—</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Waterman's Store</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Md.</u>				13b. COUNTY <u>Wicomico</u>		13c. CITY OR TOWN <u>Tyaskin</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <u>Franklin A. Cox</u>				15. MOTHER'S MAIDEN NAME First Middle Last <u>Russell TWiggs</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give year or dates of service)				16b. SOCIAL SECURITY NO. <u>—</u>		17 INFORMANT <u>Elmer Cox, Tyaskin, Md</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1 DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) <u>arteriosclerosis</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>—</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____							
22a. I certify that (I) (this hospital) attended the deceased from <u>10/31, 1961</u> to <u>death</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/27</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>Ernest M. Larmore</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/26/69</u>					
22d. PHYSICIAN'S NAME (Type) <u>ERNEST M. LARMORE</u>		22e. ADDRESS <u>DELMAR, DE.</u>									
23a. BURIAL, CREMATION, REBURYAL (Specify) <u>Burial</u>		23b. DATE <u>4/28/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bivalve Cem</u>				23d. LOCATION (City or Town) (County) (State) <u>Bivalve Md.</u>			
24. FUNERAL DIRECTOR <u>Mr. J. Messing</u>		ADDRESS <u>Bivalve, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 30 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06123

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06119

1. DECEASED NAME (Type or print) <i>CLARENCE Earl DASHIELL</i>			2a. DATE OF DEATH Month <i>4</i> Day <i>1969</i> Year <i>1969</i>			2b. HOUR <i>8 10</i> AM				
3. SEX <i>MALE</i>		4. RACE <i>W. Negro</i>		5. DATE OF BIRTH <i>1-3-1898</i>		6. AGE (in years last birthday) <i>71</i> YRS		7. IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN		
7a. BIRTHPLACE (State or foreign country) <i>Frederick</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i> Md				
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Peninsula General</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>WICOMICO</i>		13c. CITY OR TOWN <i>FRUITLAND</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>ST. LUKES Road</i>		
14. FATHER'S NAME First <i>John</i> Middle <i>Washell</i> Last <i>Washell</i>			15. MOTHER'S MAIDEN NAME First <i>Kecilia</i> Middle <i>James</i> Last <i>James</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>			16b. SOCIAL SECURITY NO <i>217-09-8095</i>		17. INFORMANT <i>Clarence E. Washell Jr.</i>		18. ADDRESS <i>8152 W. W. Washell Dr. Fruitland, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Pyelonephritis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Urethral Obstruction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>~ 2 yrs</i> <i>~ 2 yrs</i> <i>> 2 yrs</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pulmonary edema, Poss CHF</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>319</i> <i>1969</i> to <i>414</i> <i>1969</i> , that (I) (we) last saw the deceased alive on <i>414</i> <i>1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <i>John M. Steffen</i>					22c. DATE SIGNED <i>4/5/69</i>					
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>4-9-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Calvary</i>		23d. LOCATION (City or Town) (County) (State) <i>Fruitland Wicomico Md.</i>				
24. FUNERAL DIRECTOR <i>Korinna B. Jolley</i>					25a. REC'D BY REGISTRAR <i>APR 15 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06124 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06120

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR
PAMELA LORRAINE DAVIS						4/27 1969			4:15 P
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Female	White	May 24, 1955	13 YRS					April 27 1969	4:15 P
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md
Maryland		USA				WICOMICO			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury			Peninsula General Hospital			None - Student			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland			Wicomico		Salisbury		421 Priscilla Street		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Harry J. Davis						Mona Leslie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT (Father) ADDRESS				
No			--		Mr. Harry J. Davis, Jr., Salisbury, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull</u>									minutes
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			3:20 P M 4-27-69		Fell from horse.				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
		highway		Route 361, Manokin, Somerset, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)			Earl L. Royer, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		April 28 / 1969	
			409 Camden Ave., Salisbury, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			April 29, 1969		Wicomico Memorial Park		Salisbury, Wicomico, Maryland		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
HOLLOWAY & COMPANY, SALISBURY, MARYLAND					APR 30 1969		Charles Judge		

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06125

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06121

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
MARY HESTER DEFORGE						Month Day Year			4/12 1969			11:35 A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 1 YEAR		8. UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR			
Female	White	December 7, 1901	67 YRS	MONTHS	DAYS	HOURS	MIN.	April 11 1969			11:35 A.M.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Maryland		USA				Wicomico Md.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury			Peninsula General Hospital			Housewife			---					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland			Wicomico		Salisbury				308 Marshall Street					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
Grafton Mills			Lydia Hatton											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT (Son) ADDRESS									
No			214-18-4298A		Mr. George W. Parker, Salisbury, Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>												minutes		
4/10/69														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
DUE TO, OR AS A CONSEQUENCE OF														
(b) _____														
(c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
				HOUR A.M. P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED						
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				April 15 /1969						
Earl L. Royer, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
409 Camden Ave. Salisbury, Md.				ADDRESS (Street, city, town, or county)										
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)				
Burial				April 16, 1969		Wicomico Memorial Park				Salisbury, Wicomico, Maryland				
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
HOLLOWAY & COMPANY, SALISBURY, MARYLAND								DATE APR 18 1969		R. Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
WALTER J. DICKEY						April 25, 1969		4:15 PM	
3 SEX	4 RACE		5. DATE OF BIRTH			6 AGE (n years last birthday)	7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.
Male	White		OCT. 25, 1882			86			
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
MARYLAND	U.S.A.				WICOMICO Md.				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Salisbury		Deer's Head State Hospital			RETIRED FARMER				
13a U.S.A. RESIDENCE (Where deceased admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Wicomico		Salisbury					
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
THOMAS DICKEY						SARAH JANE MOORE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT Address			
						W. DeWITT DICKEY HYATTSVILLE, MD.			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u>								24 hrs	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchopneumonia and pulmonary edema</u>								1 day	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <u>Carcinoma of the face</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (A) (this hospital) attended the deceased from <u>September 25, 1968</u> , to <u>April 25, 1969</u> , that (A) (we) last saw the deceased alive on <u>April 25, 1969</u> , and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (not) view the body after death									
22b SIGNATURE <u>A. C. Mitchell, M.D.</u>					22c DATE SIGNED <u>4/28/69</u>				
22d PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M. D.</u>					22e ADDRESS <u>Deer's Head State Hospital, Salisbury,</u>				
23a BURIAL, CREMATION, REMOVED (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL		4/29/1969		OLK GROVE CEMETERY		JESTERVILLE, MD.			
24 FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE		
LEVIN R. WILSON PRINCESS ANNE, MD.					MAY 5 1969		<u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Box 1

06127

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06123

1. DECEASED NAME (Type or print) First Middle Last VICTOR RAYMOND Dinges			2a. DATE OF DEATH Month Day Year April 9 69			2b. HOUR 2 35 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH SEPT. 27, 1886		6. AGE (In years last birthday) 82 YRS.	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.		
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Peninsula General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER		12b. KIND OF BUSINESS OR INDUSTRY RETIRED
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY WORCESTER	13c. CITY OR TOWN BERLIN	13d. INSIDE CITY, TOWN? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER MAIN ST	
14. FATHER'S NAME First Middle Last PETER DINGES			15. MOTHER'S MAIDEN NAME First Middle Last MOLLIE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No No		16b. SOCIAL SECURITY NO 2-17-36-0602		17. INFORMANT Address Mr. Fred Dinges Berlin Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY 1229 IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (the hospital) attended the deceased from March 8, 1969, to April 9, 1969, that (I) (the) last saw the deceased alive on April 8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Shawes C. Hef y. M.D.				22c. DATE SIGNED 4-11-69		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS Pine Bluff Road, Salisbury Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/11/69		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) BERLIN WOR MD
24. FUNERAL DIRECTOR Anne A. Burby Berlin Md.				25a. REC'D BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE V. C. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06128										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Ellen Bell Doane						April Month 10 Day 1969		1:30 PM		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. UNDER 1 YEAR		
Female		Colored		2-2-1908		61 YRS		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Winchester		U.S.A.				Wicomico Md				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Salisbury			Deer's Head State Hospital							
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Somerset		Princess Anne				Route # 2	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
William Smith			Leah Wilson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b SOCIAL SECURITY NO.		17. INFORMANT		Address			
			212-14-4687A		Iris Doane		Princess Anne Md. Rt #2 Box 249			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent cerebral thrombosis								8 months		
4122 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic cardiovascular disease								Years		
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (A) (this hospital) attended the deceased from 8/14, 1968, to 4/10, 1969, that (X) (we) last saw the deceased alive on April 10, 1969, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did) view the body after death.										
22b. SIGNATURE						22c. DATE SIGNED				
L. V. Maldve, M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>						4/10/69				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
L. V. Maldve						Deer's Head Hospital; Salisbury, Md. 21801				
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4-13-69		John Wesley		Princess Anne Som. Md.				
24. FUNERAL DIRECTOR						25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Loretta B. Jolley - Jersey Rd. Rt #2 Salisbury Md.						APR 21 1969		Charles Judge		



TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or Print) WILLIAM ALLEN DOUGHERTY		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> April 4 1969		2b. HOUR 2:15 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Sept. 14, 1904	6. AGE (In years last birthday) 64 YRS.	7. UNDER 1 YEAR MONTHS 0 DAYS 0	8. UNDER 24 HRS. HOURS 0 MIN 0
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Wicomico		2c. DATE PRONOUNCED DEAD April 4 1969		2d. HOUR 2:15 P.M.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Peninsula General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Railro. Transit	
12b. KIND OF BUSINESS OR INDUSTRY Bus Operator		13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. CITY OR TOWN Mardela Springs	
13c. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER			
14. FATHER'S NAME First John Middle Dougherty Last Adams		15. MOTHER'S MAIDEN NAME First Martha Middle Adams Last Adams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16b. SOCIAL SECURITY NO 415-18-1		17. INFORMANT ADDRESS Mrs. Katherine A. Dougherty, Mardela Springs	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Coronary occlusion					
DUE TO, OR AS A CONSEQUENCE OF					
(b) 4109					
DUE TO, OR AS A CONSEQUENCE OF					
(c) 4109					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
Diagnosis - coronary artery disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Philip A. Tusk M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4-4-69	
EXAMINER'S NAME (Type) Philip A. Tusk		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 7, 1969		23c. NAME OF CEMETERY OR CREMATORY Mardela Memorial Cemetery, Mardela Springs, Maryland	
23d. LOCATION (City or Town) (County) (State)		23e. REC'D BY REGISTRAR APR 11 1969		23f. REGISTRAR'S SIGNATURE William A. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
06130									
06126									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Mary Mageline Downing						April 10 1969			1 P.M.
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Colored		Jan. 28, 1877		92 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Va.		U.S.A.				Wicomico Md.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Salisbury			Deer's Head Hospital			Domestic			Housewife
13a. USUAL RES. DENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Worcester		Pocomoke				401 Oxford Street
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
John Cropper			Caroline White						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT		Address		
No					Alice D. Doane		Pocomoke, Md.		
18 CAUSE OF DEATH (Enter any one cause per line for (a) (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									9 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									Years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/18</u> , 19 <u>62</u> , to <u>4/10</u> , 19 <u>69</u> , that (we) last saw the deceased alive on <u>4/10</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <u>L. V. Maldve, M. D.</u> DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>4/10/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>					22e. ADDRESS <u>Deer's Head State Hospital; Salisbury, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4-13-69		Mt. Hope Cem.		Stockton Wor. Md.			
24. FUNERAL DIRECTOR <u>Samuel Sayer</u> ADDRESS <u>New Church, Va.</u>					25a. RECD BY REGISTRAR DATE <u>APR 15 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Sayer</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06131 CERTIFICATE OF DEATH 06127										
1. DECEASED NAME (Type or print) VIRGINIA MAY ELLINGSWORTH			2a. DATE OF DEATH Month APRIL Day 8 Year 1969			2b. HOUR 6:30 MIN AM				
3. SEX F		4. RACE CAY		5. DATE OF BIRTH 26 DEC 16		6. AGE (in years last birthday) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 		
7a. BIRTHPLACE (State or foreign country) DELA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico				
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tal give street address) Peninsula General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE DELA			13b. COUNTY SUSSEX		13c. CITY OR TOWN GEORGETOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD 5 Box 104 (ROGERS AVE)	
14. FATHER'S NAME HOLLIS			15. MOTHER'S MAIDEN NAME Blanche N. MARVEL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO 232-05-4017		17. INFORMANT J. HENRY ELLINGSWORTH (AS ABOVE)					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) CA OVARY WITH METASTASIS										
183.0 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE James P. Gallaher MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4/8/69		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS SALISBURY MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11 APR 69		23c. NAME OF CEMETERY OR CREMATORY ST JOHN'S		23d. LOCATION (City or Town) (County) (State) GEORGETOWN Dela.				
24. FUNERAL DIRECTOR Dodd-Carey Inc. Georgetown Dela.				25a. REC'D BY REGISTRAR APR 11 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, entombment, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
MONIE			WALTER			GLADDEN		April 17, 1969 8:55 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR		
Male		White		Oct 26-1883		85 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				WICOMICO Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Deer's Head State Hospital			Retired		Waterman		
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Somerset		Chance		YES		--	
14. FATHER'S NAME			5. MOTHER'S MAIDEN NAME							
George			Elizabeth			Parks				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT				
No			Unknown			Elbert Gladden				
						Chance Md 21816				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident									4 days	
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis with many small Cerebral										
DUE TO, OR AS A CONSEQUENCE OF (c) Vascular Accidents										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Intertrochanteric Fracture Left Hip with Roger Anderson Splint										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town		
22a. I certify that (A) (this hospital) attended the deceased from March 5, 1969, to April 17, 1969, that (H) (we) last saw the deceased alive on April 17, 1969, and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						DEGREE		22c. DATE SIGNED		
A. C. Mitchell						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		4/17/69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
A. C. Mitchell, M. D.						Deer's Head Hospital; Salisbury, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4/19/69		Rock Creek Cemetery		Chance Som Md				
24. FUNERAL DIRECTOR						25a. USED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Erroy Webster						DATE		APR 22 1969		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
06133 CERTIFICATE OF DEATH 06129											
1 DECEASED NAME (Type or print)			First ELMA		Middle HURD		Last HALES		2a DATE OF DEATH Month Day Year April 24 1969		2b HOUR M
3 SEX Female		4 RACE White		5 DATE OF BIRTH January 5, 1892			6 AGE (In years last birthday) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Ohio		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WICOMICO					Md
10 CITY OR TOWN OF DEATH Salisbury			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springhill Sanitarium, Inc.			12a USUA. OCCUPATION (Kind of work done during most of work life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Wicomico		13c CITY OR TOWN Salisbury		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Rt. 1		
14 FATHER'S NAME First Middle Last John H. Barnhardt			15 MOTHER'S MA DEN. NAME First Middle Last Lida C. Bash								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b SOCIAL SECURITY NO		17 INFORMANT (Grandson) Address Box 688 Mr. Charles R. Adams, Hebron, Maryland						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u> 404X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Generalized Arterio Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CVA. Diabetes mellitus</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home, farm, street, factory) Office building, etc.		21f LOCATION Street or RFD No City or Town County State							
22a I certify that (I) (this hospital) attended the deceased from <u>4-20, 1969</u> , to <u>4-24, 1969</u> , that (I) (we) lost saw the deceased alive on <u>4-23, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Philip A. Insley</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED April 25/1969			
22d PHYSICIAN'S NAME (Type) Dr. Philip A. Insley						22e ADDRESS Salisbury, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE April 26, 1969		23c NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park			23d LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland				
24 FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND						ADDRESS APR 30 1969		25 REGISTRAR'S SIGNATURE <u>James Judge</u>			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18b & 21b Film 412
5-5-69 ams
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06130

1 DECEASED-NAME (Type or Print) HAROLD PUTNAM HANLEY		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 4 Day 22 Year 1969		2b HOUR 10:02 M
3 SEX Male	4 RACE White	5 DATE OF BIRTH 3-15-12	6 AGE (In years last birthday) 57 YRS	7 IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a BIRTHPLACE (State or foreign country) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Wicomico	
10 CITY OR TOWN OF DEATH Salisbury	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cook	12b KIND OF BUSINESS OR INDUSTRY Self	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Va.		13b COUNTY Accomac	13c CITY OR TOWN Chincoteague	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
14 FATHER'S NAME First Unknown Middle Unknown Last Unknown		15 MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. II		16b SOCIAL SECURITY NO 150-09-2490	17 INFORMANT ADDRESS Edna Hanley, Chincoteague, Virginia	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemothorax DUE TO, OR AS A CONSEQUENCE OF (b) Fractured ribs DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 46 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. 3-27-69 P.M. 3-27-69	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fell in shower at home.		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) own home	21f LOCATION Street or R.F.D. No. 135 Clark St. City or Town Chincoteague County Accomac State Va.		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED April 28, 1969
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		ADDRESS (Street, city, town, or county)		
23a BURIAL, CREMATION, Burial (Specify)	23b DATE 4-25-69	23c NAME OF CEMETERY OR CREMATORY Mechanics Cemetery	23d LOCATION (City or Town) Chincoteague (County) Virginia (State)	
24 FUNERAL DIRECTOR Salyer Funeral Home, Chincoteague, Va.		25a REC'D BY REGISTRAR MAY 1 1969		25b REGISTRAR'S SIGNATURE Charles Judge

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06131
CERTIFICATE OF DEATH

06135		1 DECEASED NAME (Type or print) ETRA FRANCES HEARN		2a. DATE OF DEATH Month APRIL Day 2 Year 1969		2b. HOUR 8:35 AM	
3 SEX Female		4. RACE White		5. DATE OF BIRTH June 26, 1886		6. AGE (In years last birthday) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House wife		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Joseph W. Maddox		15. MOTHER'S MAIDEN NAME First Middle Last Sarah Martha Shockley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		16b. SOCIAL SECURITY NO. 218-48-5975		17. INFORMANT Address Mrs. Stella F. Solloway, Snow Hill, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertensive Heart Disease							
19a. DATE OF OPERATION 3-30		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hypertensive Heart Disease		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.O. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3-30 , 19 69 , to 4-2 , 19 69 , that (I) (we) lost saw the deceased alive on 4-2 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David J. Gilmore				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED April 2, 1969	
22d. PHYSICIAN'S NAME (Type) David J. Gilmore				22e. ADDRESS Medical Center Md. Salisbury			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE April 5, 1969		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland	
24. FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR APR 8 1969		25b. REGISTRAR'S SIGNATURE Charles Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06136

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06136

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR M		
3 SEX Male			4 RACE Negro		5 DATE OF BIRTH 1903		6 AGE (In years last birthday) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Wicomico Md					
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER			12b KIND OF BUSINESS OR INDUSTRY ST-Successful		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md			13b COUNTY Wicomico		13c CITY OR TOWN Snow Hill		13d W/IDE CITY LIM-157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 203 S. Collins St		
14. FATHER'S NAME First Middle Last Cirkawa			15. MOTHER'S MAIDEN NAME First Middle Last Cirkawa								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown No			16b SOCIAL SECURITY NO (If yes give year or dates of service) 138-18-2624		17 INFORMANT Address 1465 Hilda Carter Snow Hill MD						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4125 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerosis Obliterans (lower extremities)</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <u>Mar. 27, 1969</u> to <u>April 11, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 11, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>David J. Dilmore</u>						DEGREE ATTENDING <input checked="" type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS DIRECTOR PHYS			22c DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)						22e ADDRESS					
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE 4/13/1969		23c NAME OF CEMETERY OR CREMATORY Mt Zion Baptist			23d LOCATION (City or Town) (County) (State) Snow Hill MD.			
24 FUNERAL DIRECTOR ADDRESS Gerald C. Saunders, Snow Hill, MD.						25a REC'D BY REGISTRAR DATE APR 15 1969			25b REGISTRAR'S SIGNATURE William Judge		

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06137

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06133

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) JAMES		18 Middle R		19 Last JOHNSON		2a. DATE OF DEATH Month April Day 30 , Year 1969		2b. HOUR 8:55 P M	
3. SEX Male		4 RACE Colored		5 DATE OF BIRTH 9/23/95		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deer's Head State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Waterman		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Bellevue		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER --	
14 FATHER'S NAME First Middle Last Charles Johnson		15 MOTHER'S MAIDEN NAME First Middle Last Elizabeth Thomas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO 230-05 2272		17. INFORMANT Address Prunice Johnson					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration pneumonitis 486 * DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic cardiovascular disease, decompensated.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (U) (this hospital) attended the deceased from June 26 , 19 67 , to April 30 , 19 69 , that (H) (we) last saw the deceased alive on April 30 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE L. V. Maldve		DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/1/69			
22d. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22e. ADDRESS Deer's Head State Hospital, Salisbury, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE 7/5/69		23c. NAME OF CEMETERY OR CREMATORY Richards Inn		23d. LOCATION (City or Town) (County) (State) Easton MD			
24 FUNERAL DIRECTOR Charles H. Harkins		ADDRESS Easton, Md.		25a. REC'D BY REGISTRAR DATE MAY 5 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

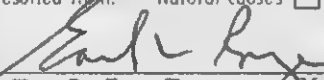
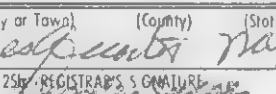
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) John Wesley Johnson						2a. DATE OF DEATH Month April Day 2 Year 69			2b. HOUR- 3 12 P M		
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH 7-31-94		6 AGE (in years last birthday) 74 YRS		IF UNDER 1 YEAR MONTHS 7 DAYS 10		IF UNDER 24 HRS HOURS 3 MIN 12	
7a. BIRTHPLACE (State or foreign country) Snow Hill		7b. CITIZEN OF WHAT COUNTRY? U.S.A		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md					
10 CITY OR TOWN OF DEATH Salisbury				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) MARYLAND STATE				13b. COUNTY Worcester		13c. CITY OR TOWN Snow Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt #1 Box 305	
14 FATHER'S NAME George A. Johnson				15 MOTHER'S MAIDEN NAME Maggie Blake							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO 214-30-7990		17 INFORMANT HARBACOT Johnson Rt #1 Box 305				Address Snow Hill, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4122 DUE TO, OR AS A CONSEQUENCE OF Hypertensive C.V. Disease											
DUE TO, OR AS A CONSEQUENCE OF (b) 											
DUE TO, OR AS A CONSEQUENCE OF (c) 											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 4 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION: Street or R.F.D. No. 3/20/19 City or Town Salisbury County Worcester State Md							
22a. I certify that (I) (this hospital) attended the deceased from 3/20/19 to 4/2/19 , that (I) (we) last saw the deceased alive on 4/1/19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE Burton						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/2/19			
22d. PHYSICIAN'S NAME (Type) Burton		22e. ADDRESS PENINSULA GENERAL Hospital									
23a. BURIAL (CREMATION, REMOVAL) (Specify) Burial		23b. DATE 4-5-69		23c. NAME OF CEMETERY OR CREMATORY Mt. Wesley				23d. LOCATION (City or Town) Snow Hill (County) Worcester (State) Md.			
24 FUNERAL DIRECTOR Loretta B. Jolley		ADDRESS Jersey Rd # 2 Salisbury, Md.		25a. REC'D BY REGISTRAR APR 10 1969				25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
1. DECEASED NAME (Type or Print)			First ELLA			Middle Jones			Last KELLAM			2a. DATE KNOWN OF DEATH EST. <input type="checkbox"/> Month Day Year MATED <input checked="" type="checkbox"/> 4-27-69			2b. HOUR M				
3. SEX F		4. RACE AA		5. DATE OF BIRTH 3-8-30		6. AGE (In years and birthday) 40 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 5 Day 2 Year 1969			2d. HOUR 11:20 AM				
7a. BIRTHPLACE (State or foreign country) Wicomico				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. COUNTY OF DEATH Wicomico				Md.			
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wicomico River				12a. USUAL OCCUPATION (Kind of work done during most of work life even if retired) Domestic				12b. KIND OF BUSINESS OR INDUSTRY none							
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.				13b. COUNTY Wicomico				13c. CITY OR TOWN Salisbury				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 671 Fitzwater St.					
14. FATHER'S NAME First Middle Last Charles Jones						15. MOTHER'S MAIDEN NAME First Middle Last Mahalia Brown													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16b. SOCIAL SECURITY NO (If yes give year and dates of service) ?						17. INFORMANT Mahalia Jones						ADDRESS	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. estimated P.M. 4-27 1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Undetermined - found drowned											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Wicomico River				21f. LOCATION Street or R.F.D. No --				City or Town Salisbury				County Wic.		State Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Pending																			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Earl L. Royer, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED May 5, 1969											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 5-7-69				23c. NAME OF CEMETERY OR CREMATORY Home of Queen				23d. LOCATION (City or Town) (County) (State) Salisbury Wic. Md.							
24. FUNERAL DIRECTOR Booker West, Salisbury, Md.				ADDRESS				25a. REC'D BY REGISTRAR MAY 8 1969				25b. REGISTRAR'S SIGNATURE 							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06140

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06136

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Frances W. Kemp</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>13</i> Year <i>69</i>			2b. HOUR <i>2:19</i> M	
3. SEX <i>Female</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>OCT. 30, 1892</i>		6. AGE (In years last birthday) <i>76</i> YRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>WICOMICO</i>	
10. CITY OR TOWN OF DEATH <i>SALISBURY</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>PENINSULA GENERAL HOSPITAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>NONE</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission to State) <i>MD.</i>		13b. COUNTY <i>SOMERSET</i>		13c. CITY OR TOWN <i>PRINCESS ANNE</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <i>ROBERT LEE</i> Middle <i>WATSON</i>		15. MOTHER'S MAIDEN NAME First <i>EILEN</i> Middle <i>DOLAN</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (if yes give war or dates of service)			
16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>ROBERT KEMP PRINCESS ANNE, MD.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral thromboses</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <i>1 day</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>4-12, 1969</i> , to <i>4-13, 1969</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Wilbur S. Ellis</i>				DEGREE ATTENDING <input type="checkbox"/> MED. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4-14-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Wilbur Ellis</i>				22e. ADDRESS <i>Medical Center Salisbury, Md.</i>			
23a. BURIAL, CREMATION, or other disposition <i>BURIAL</i>		23b. DATE <i>4/15/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Manokin Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>PRINCESS ANNE, MD.</i>	
24. FUNERAL DIRECTOR <i>LEVIN R. WILSON</i>				ADDRESS <i>PRINCESS ANNE, D.</i>		25a. REC'D BY REGISTRAR <i>APR 17 1969</i>	
						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 5
45M 69

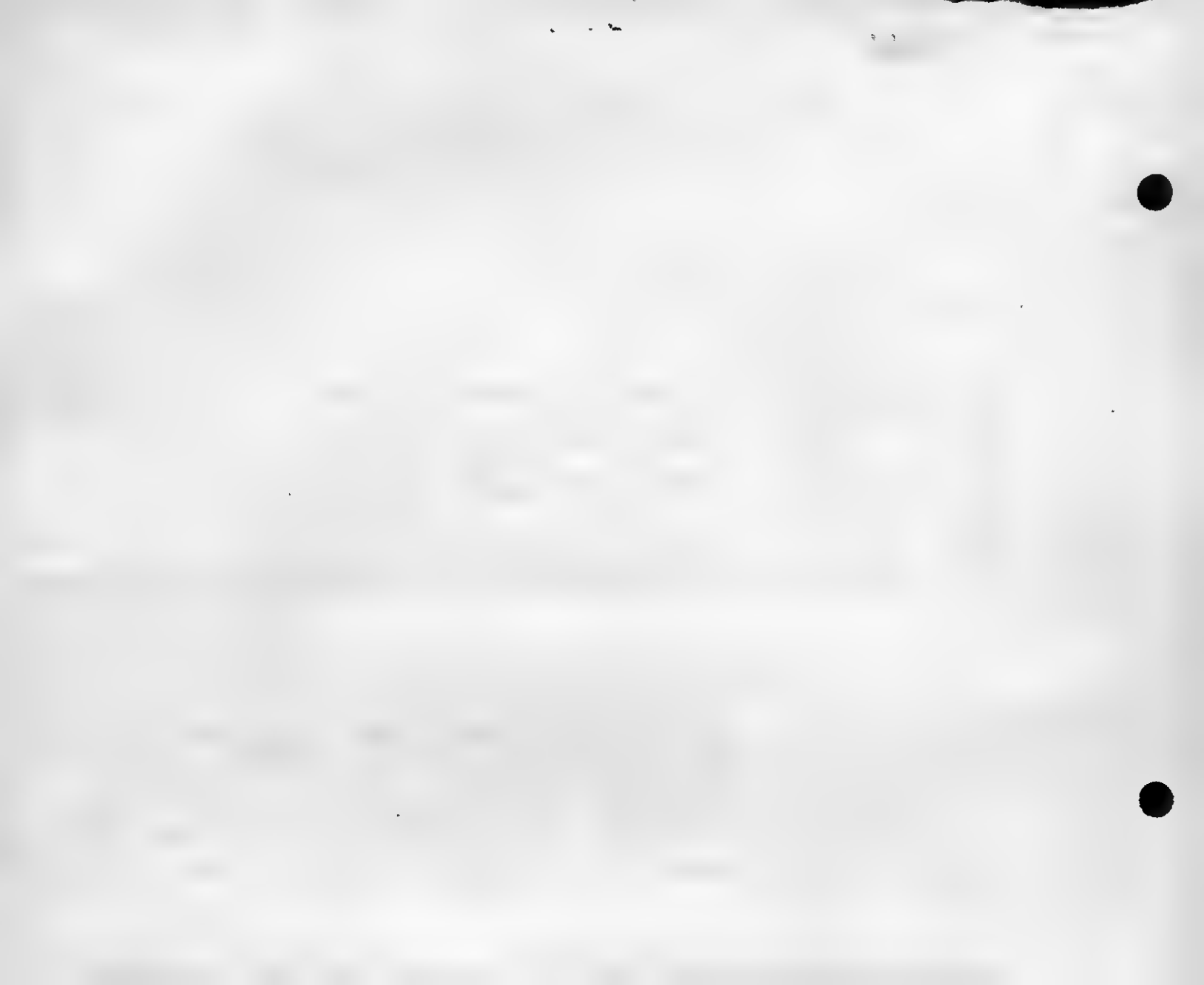
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06141

06137

1 DECEASED NAME (Type or print) LAURA EMMA LECATES			2a. DATE OF DEATH Month April Day 24 Year 1969		2b. HOUR 5:40PM
3 SEX Female	4. RACE White	5. DATE OF BIRTH September 5, 1895		6 AGE (In years last birthday) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Delaware	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WICOMICO Md	
10. CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Secretary (Ins. & Real Est.)	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland		13b COUNTY Wicomico	13c CITY OR TOWN Salisbury	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER R.D., Baysinger Mobil Ct.
14 FATHER'S NAME First Middle Last Charles E. King			15 MOTHER'S MAIDEN NAME First Middle Last Lillie West		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b SOCIAL SECURITY NO 213-22-9055		17 INFORMANT (Husband) Address Mr. Samuel S. LeCates, Salisbury, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congenital heart failure DUE TO, OR AS A CONSEQUENCE OF (b) prev. myocardial infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF					APPROPRIATE REFERENCE BETWEEN ONSET AND DEATH 1 wk. 2 yr.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) generalized atherosclerosis - pulmonary emphysema					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from May 24, 1969 , to Apr. 24, 1969 , that (I) (we) last saw the deceased alive on May 24, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE E. M. Beardsley				22c DATE SIGNED April 25, 1969	
22d PHYSICIAN'S NAME (Type) Dr. E. M. Beardsley				22e ADDRESS Maryland Avenue, Salisbury, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE April 28, 1969		23c NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	
				23d LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a REC'D BY REGISTRAR APR 30 1969	
				25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06142		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06138					
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		2b HOUR	
ZELDA				LITOW				Month Day Year APRIL 27 1969		11:35 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		MAY 5, 1920		48 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
BAVARIA		U.S.A.				Wicomico				Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
SALISBURY		PENINSULA GENERAL HOSPITAL		HOUSEWIFE		AT HOME					
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d HAS DE CITY LIMITS?		13e. STREET AND NUMBER			
MARYLAND				SALISBURY		YES <input type="checkbox"/> NO <input type="checkbox"/>		1012 EVERGREEN AVENUE			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
ISRAEL				GILEROVITZ				DENA		?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT		Address		SALISBURY, MD.			
NO				MR. LITMAN LITOW,		1012 EVERGREEN AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Overwhelming Infection</u>											
284X DUE TO, OR AS A CONSEQUENCE OF <u>Right Upper lobe pneumonia</u>										3 weeks.	
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last											
DUE TO, OR AS A CONSEQUENCE OF <u>Apelstic Anemia</u>										18 mo.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY?										20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY	
										HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work										21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	
21f LOCATION										Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 1967, to <u>April</u> , 1969, that (I) (we) last saw the deceased alive on <u>28 April</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE										22c. DATE SIGNED	
Joseph C. Fitzgerald M.D. DEGREE											
ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22d PHYSICIAN'S NAME (Type)										22e. ADDRESS	
JOSEPH C. FITZGERALD											
23a BURIAL, CREMATION, REMOVAL (Specify)										23b DATE	
BURIAL										4-29-69	
23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town) (County) (State)	
BETH ISRAEL										SALISBURY, MARYLAND	
24 FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR	
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD										DATE APR 30 1969	
										25b. REGISTRAR'S SIGNATURE	
										[Signature]	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

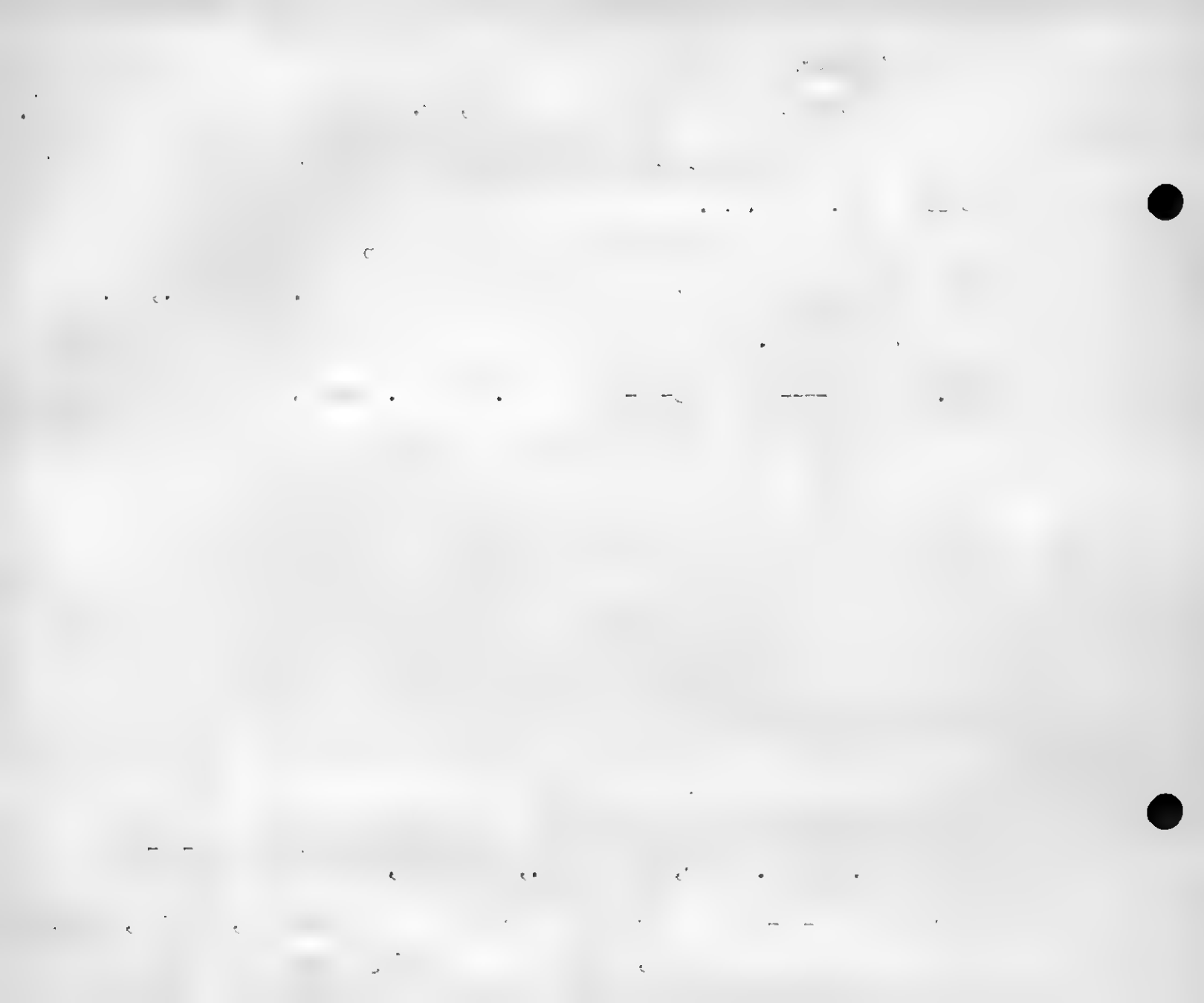
Item 5 Filing 11
4/24/69 kk

06143

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06133

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		ESTIMATED	Month	Day	Year	2b HOUR
CLARENCE EDWARD LOWMAN, Sr.					4 19 1969						2:10 A.M.
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c DATE PRONOUNCED DEAD		2d HOUR
Male	White	April 8, 1917		57 YRS	MONTHS DAYS		HOURS MIN		4 19 1969		2:10 A.M.
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md			
MARIUSA, ILL.		U.S.A.				Wicomico					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Salisbury		Peninsula General Hospital		Carpenter Boats		Cris Craft					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Mt. Herman Rd., Rt. #7			
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last		
John W. Lowman					Blanche Robey						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS					
No.		213-01-8618		Mrs. Sally B. Lowman, See Sec 13							
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis</u>											days
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
CAUSE OF DEATH		HOUR A.M. P.M. 19									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)		Dr. Earl L. Royer, Camden Ave., Salisbury, Maryland								4-21-1969	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town)		(County)		(State)	
Burial		4-22-1969		Wicomico Memorial Park		Salisbury, Wicomico, Maryland					
24 FUNERAL DIRECTOR				ADDRESS				25a RECD BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Hill Funeral Home Salisbury, Maryland								APR 22 1969		J. C. ...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
06144 CERTIFICATE OF DEATH 06140											
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR		
WILLIAM			-----		MCDANIEL	Month Day Year April 14 1969			7:50AM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Male		White		February 28, 1898		71 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Kentucky		USA				WICOMICO Md					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital				Retired Miner		Mining			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Wicomico		Parsonsborg		YES <input type="checkbox"/> NO <input type="checkbox"/>		Walston Switch Road		
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
John					McDaniel	Sarah					(unknown)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT (Wife)			Address			
No			232-12-2380A		Mrs. Maggie McDaniel			Parsonsborg, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>										7 days	
4339 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Diabetes mellitus, ASCVP, congestive failure</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/6/69</u> , 19 <u>69</u> , to <u>4/14/69</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>4/14/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Alberta Mattax Polin</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
								April 15/1969			
22d. PHYSICIAN'S NAME (Type) <u>Dr. Alberta Mattax Polin</u>						22e. ADDRESS <u>707 Camden Ave., Salisbury, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			April 16, 1969		Springhill Memory Gardens		Salisbury, Wicomico, Maryland				
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>						ADDRESS		25. REC'D BY REGISTRAR DATE <u>APR 18 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06145

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M
EDWARD MARVIN				MERRILL	APRIL 11 69		9A
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	
Male	White		June 22, 1886		82 YRS		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Maryland	U.S.A.				WICOMICO Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula Gen. Hosp.		Carpenter		Building	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET AND NUMBER	
Maryland		Worcester		Pocomoke		Market Street, Ext.	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME					
First Middle Last		First Middle Last					
Edward Fillmore		Merrill		Harriett Elizabeth Clarke			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT Address			
No		218-16-8031		Mrs Julia Merrill, Pocomoke, Maryland			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Mycocardia Infarct</u>							1 day
4109 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical exam ner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-9-1969 to 4-11-1969, that (I) (we) saw the deceased alive on 4-11-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Wilbur Ellis</u>				22c. DATE SIGNED <u>4-14-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Wilbur Ellis</u>				22e. ADDRESS <u>MEDICAL CENTER Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY		23d. LOCATION (City or Town) (County) (State)	
Burial		4-14-1969		First Baptist		Pocomoke-Worcester-Md.	
24. FUNERAL DIRECTOR <u>Robert H. Watson</u>				25a. REC'D BY REGISTRAR <u>APR 17 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>Pocomoke, Md.</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
1 DECEASED NAME (Type or print)			First			Middle			Last			2a DATE OF DEATH			2b HOUR								
Monie R. Messick									April			Month			Day			Year			4:40 P.M.		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS								
male			White			5/16/1904			64 YRS.			MONTHS			DAYS			HOURS			MIN		
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. COUNTY OF DEATH											
Md.			U.S.			WIDOWED			DIVORCED			Wicomico, Md.											
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY														
521564			Dennett Gen. Hosp.			L. B. Sorensen																	
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER											
Md.			Wicomico			Bridgetown			YES			NO			Employee								
14 FATHER'S NAME			First			Middle			Last			15 MOTHER'S MAIDEN NAME			First			Middle			Last		
Wade			H.			Messick			E. L. Sore			J. J. Sore											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT																	
No			214-16-1978			Mary Messick, Bridgetown, Md.																	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												Arteriosclerotic Heart Disease											
4123																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																							
DUE TO, OR AS A CONSEQUENCE OF																							
(b)																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
Hemorrhage from duodenal ulcer. severe cerebral arteriosclerosis																							
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
						YES			NO														
21a ACCIDENT WAS UNDERLYING			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																	
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year																				
			P.M.			19																	
21d INJURY OCCURRED			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION			Street or R.F.D. No			City or Town			County			State					
While <input type="checkbox"/> Not while <input type="checkbox"/>																							
at work <input type="checkbox"/>																							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																							
22b SIGNATURE			DEGREE			ATTENDING PHYS.			MED. DIRECTOR			STAFF PHYS.			22c. DATE SIGNED								
David J. Gilmore						<input checked="" type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>			4/13/69								
22d PHYSICIAN'S NAME (Type)			22e ADDRESS																				
David J. Gilmore			521564, Md.																				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)			(County)			(State)								
Burial			4/16/69			Bridgetown Cem.			Bridgetown			Md.											
24 FUNERAL DIRECTOR			25a DEED BY REGISTRAR			25b REGISTRAR'S SIGNATURE																	
E. J. Messick, Bridgetown, Md.			APR 16 1969																				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

06147										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06145																																							
Item 7 Film Roll 4/15/69 kk										CERTIFICATE OF DEATH																																																	
1 DECEASED NAME (Type or print) <i>John Emil MILLER</i>										2a. DATE OF DEATH Month <i>April</i> Day <i>7</i> Year <i>1969</i>										2b. HOUR <i>4:30</i> M																																							
3 SEX <i>MALE</i>										4. RACE <i>White</i>										5. DATE OF BIRTH <i>March 4, 1899</i>										6. AGE (In years last birthday) <i>70</i> YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) <i>Germany</i>										7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH <i>Wicomico</i> Md																													
10. CITY OR TOWN OF DEATH <i>Salisbury</i>										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Peninsula General</i>										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Del</i>										13b. COUNTY <i>Duross</i>										13c. CITY OR TOWN <i>Salmon</i>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER <i>Rd 1</i>																			
14. FATHER'S NAME First <i>Alvin</i> Middle <i>Miller</i> Last <i>Hellon</i>										15. MOTHER'S MAIDEN NAME First <i>Lensch</i> Middle <i>Lensch</i> Last <i>Lensch</i>																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO. <i>163-03-9103</i>										17. INFORMANT <i>Anna L Miller</i> Address <i>Salmon Del</i>																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))										PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Ventricular A-systole</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular Disease</i>																																																	
										DUE TO, OR AS A CONSEQUENCE OF (c)																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC										21f. LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from <i>4-7-1967</i> , to <i>4-7-1967</i> , that (I) (we) last saw the deceased alive on <i>4-7-1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE <i>James C. Miller</i>										22c. DATE SIGNED <i>4-7-67</i>										22d. PHYSICIAN'S NAME (Type) <i>Medical Center Salisbury Md</i>																																							
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>										23b. DATE <i>4/10/69</i>										23c. NAME OF CEMETERY OR CREMATORY <i>Frankwood Cem</i>										23d. LOCATION (City or Town) (County) (State) <i>Salmon Del</i>																													
24. FUNERAL DIRECTOR <i>Wallace A. Ward</i>										ADDRESS <i>Salmon Del</i>										25a. DATE BY REGISTRAR <i>APR 10 1969</i>										25b. REGISTRAR'S SIGNATURE <i>James C. Miller</i>																													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 1 hour after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06148

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06144

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
MYRTIS			LUCILLE	MOORE	April 15 1969			10:25 PM			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		March 23, 1913		56 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md.		
Maryland		USA				WICOMICO					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital			Housewife			----		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Wicomico		Salisbury				113 Princeton Avenue		
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Ullman			Owens	Lucy	Bounds						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO		17 INFORMANT (Husband)			Address			
			212-12-3047		Mr. James F. Moore, Salisbury, Maryland						
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic lesions</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Clear Cell Carcinoma with removal of Rt Kidney</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 yrs. before</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.D. No City or Town County State					
						April 15 1969					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on April 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE <u>Carrie Hearn</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED April 16 / 1969			
22d. PHYSICIAN'S NAME (Type) Dr. Carrie Hearn						22e. ADDRESS N. Division Street, Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE April 18, 1969		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland				
24 FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND						25a. REC'D BY REGISTRAR APR 21 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06149 CERTIFICATE OF DEATH 06145										
1. DECEASED-NAME (Type or print) First Middle Last MILTON JOHN MORGAN			2a. DATE OF DEATH Month Day Year April 18 1969			2b. HOUR 11A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH January 25, 1905		6. AGE (In years last birthday) 64 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Roanoke, Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md				
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital			2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Lumber Mill	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 519 E. Church Street	
14. FATHER'S NAME First Middle Last John Morgan			15. MOTHER'S M.A.D.E.N. NAME First Middle Last Elizabeth (unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No			16b. SOCIAL SECURITY NO		17. INFORMANT (Son) 519 Address E. Church St. Mr. Robert Lee Morgan, Salisbury, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) <u>Arteriosclerotic cardiovascular disease</u> stating the underlying cause last <u>diabetes</u> (b) <u>5 drugs</u> (c) <u>10 yrs</u> <u>unknown</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/16/69</u> 19 <u>69</u> , to <u>4/18/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/18/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE <u>Alberta Mattox Polin MD</u> 22d. PHYSICIAN'S NAME (Type) Dr. Alberta Mattox Polin					OEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 22/1969			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 22, 1969		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland				
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR DATE APR 23 1969		25b. REGISTRAR'S SIGNATURE <u>Thomas Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06150

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06146

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Frederick			First Middle Last			2a. DATE OF DEATH Month 4 Day 16 Year 69			2b. HOUR 12⁰⁰ PM		
3 SEX Male			4 RACE Caucasian			5 DATE OF BIRTH OCT. 10, 1896			6 AGE (In years lost birthday) 72 YRS.		
7a. BIRTHPLACE (State or foreign country) PENNA.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Wicomico County Md		
10. CITY OR TOWN OF DEATH Salisbury, Md			11. NAME OF HOSPITAL, OR INSTITUTION (if not in hospital give street address) Wicomico Nsg. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER			12b. KIND OF BUSINESS OR INDUSTRY PLASTIC		
13a. USLA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY CHARLOTTE			13c. CITY OR TOWN R.F.D.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME EDWARD			First Middle Last			15. MOTHER'S MAIDEN NAME TERESA			First Middle Last (UNKNOWN)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) YES			(If yes give war or dates of service) W.W.I.			16b. SOCIAL SECURITY NO. 218-05-8270			17. INFORMANT MRS. HELEN PARROTT, SEAFORD, DEL.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4369 IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from 3-7, 1969 to 4-16, 1969 , that (1) (we) last saw the deceased alive on 4-16, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Harry J. ...						22c. DATE SIGNED APR 29 1969			22d. PHYSICIAN'S NAME (Type) MP DEGREE		
23. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 4-19-69			23c. NAME OF CEMETERY OR CREMATORY BLOOMERY CEMETERY			23d. LOCATION (City or Town) (County) (State) FEDERALSBURG, CAROLINE, MD.		
24. FUNERAL DIRECTOR Williamson Funeral Home, Federalburg						25a. REC'D BY REGISTRAR DATE APR 29 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06151										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06147																																																											
1 DECEASED NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																																																	
Charlie										W.										PARSONS										APRIL										Month Day Year										M																													
3 SEX										4. RACE										5 DATE OF BIRTH										6 AGE (In years last birthday)										7 UNDER 1 YEAR										IF UNDER 24 HRS																													
Male										White										Sept. 23, 1880										88										MONTHS										DAYS										HOURS										MIN									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																																																	
Maryland										Pittsville																				Wicomico										Md																																							
10 CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Salisbury										Peninsula General										Nurse										Laborer																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																																							
Maryland										Wicomico										Pittsville										YES										no #																																							
14. FATHER'S NAME										First Middle Last										15. MOTHER'S MAIDEN NAME										First Middle Last																																																	
Joseph Parsons																				Mary Parker																																																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)										(If yes give year or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																																							
xx										xx										218-16-5398										Edwin Massey Williams, Jr.																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART 1. DEATH WAS CAUSED BY:																																																																															
IMMEDIATE CAUSE (a)										Cerebral hemorrhage																																																																					
4319																																																																															
DUE TO, OR AS A CONSEQUENCE OF																																																																															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																																																															
(b)																																																																															
DUE TO, OR AS A CONSEQUENCE OF																																																																															
(c)																																																																															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (I) (this hospital) attended the deceased from 4-5-1969, to 4-10-1969, that (I) (we) last saw the deceased alive on 4-9-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																																																																															
22b. SIGNATURE										James H. Coffey, M.D. DEGREE										ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 4-10-69																																																	
22a. PHYSICIAN'S NAME (Type)																				22e. ADDRESS										Medical Center Salisbury Md																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																																	
Burial										4/12/69										Fawnlows										Pittsville Md																																																	
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																	
Peter Whaley										Salisbury, Del										APR 14 1969										Charles Judge																																																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06152

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06148

1 DECEASED-NAME (Type or print)		First LEONA Middle MAE Last Payne		2a DATE OF DEATH Month April Day 26 Year 1969		2b HOUR 7:00 P.M.					
3 SEX Female		4 RACE White		5 DATE OF BIRTH Nov. 16, 1893		6 AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH WICOMICO		Md			
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula Gen. Hosp.		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY ---					
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Maryland		13b COUNTY Worcester		13c CITY OR TOWN Pocomoke		13d INS. DE. CITY LIM. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1313 Snow Hill Lane			
14. FATHER'S NAME First Middle Last Parker William Pruitt		15. MOTHER'S MAIDEN NAME First Middle Last Alice -- Tarr									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO 220-52-9194		17 INFORMANT Mrs Benjamin Silverthorne		Address Pocomoke, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY 4109 IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF 19c stating the underlying cause lost (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/4 hrs. 5 days.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Acute Cholecystitis & cholelithiasis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 4/25/1969 to 4/26/1969, that (I) (we) last saw the deceased alive on 4/25/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE [Signature]		DEGREE Oswald J. Burton, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Medical Center, Salisbury, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-29-1969		23c. NAME OF CEMETERY Beth Eden Cemetery		23d. LOCATION (City or Town) (County) (State) Worcester County, Maryland					
24. FUNERAL DIRECTOR Robert H. Watson		ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR MAY 1 1969		25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
CARRIE ELIZABETH PHILLIPS						Month Day Year April 23 1969			4:20PM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Female	White		February 22, 1915			54 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				WICOMICO Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury			Peninsula General Hospital			Seamstress		Shirt Factory	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland			Wicomico		Salisbury		411 Barclay Street		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Charles Mitchell						Lucinda Hudson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT (Daughter)		Address		
No			214-10-8313		Mrs. Virginia D. Matthews, Salisbury, Maryland		609 Inuit St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia secondary to</u>									<u>5 days</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>gastroenteritis</u>									
(c) <u>gastroenteritis</u>									<u>9 days</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
4-14-69			Pneumonia obstruction			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC			21f. LOCATION		City or Town County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						4-4-69		4-23-69	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-4-69</u> to <u>4-23-69</u> , that (I) (we) last saw the deceased alive on <u>4-23-69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
<u>Dr. Nevins W. Todd, Jr.</u>						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		April 26 1969	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Dr. Nevins W. Todd, Jr.						Medical Center, Salisbury, Maryland			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 26, 1969		Parsons Cemetery		Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HOLLOWAY & COMPANY, SALISBURY, MARYLAND						DATE 30 1969			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06154

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06150

1 DECEASED-NAME (Type or print) Carrie Mae Revel			2a. DATE OF DEATH Month APRIL Day 8 Year 1969			2b. HOUR 11:15 A.M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH April 3 1900		6 AGE (in years last birthday) 69 YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Delaware		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Wicomico Md			
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Peninsula General		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY own home			
13a USUAL RESIDENCE (Where deceased ordinarily lived, if institution: Residence before death) STATE Maryland COUNTY Wicomico		13b CITY OR TOWN Salisbury		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 109 Coulborn Drive			
14. FATHER'S NAME First IRB F. Middle BROWN Last BROWN			15 MOTHER'S MAIDEN NAME First ANNA M. Middle TOSEPH Last TOSEPH			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)			
16b SOCIAL SECURITY NO. 221-28-2013			17 INFORMANT Goldsberry I. Revel			Address 109 Coulborn Salisbury Md			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) 3 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April 5, 1969 , to April 8, 1969 , that (I) (we) lost saw the deceased alive on April 8, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE David J. Gilmore				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 4-12-69			
22d PHYSICIAN'S NAME (Type) DAVID J. GILMORE				22e ADDRESS MEDICAL CENTER, SALISBURY, MD.					
23a BURIAL, CREMATION, REMOVA. (Specify)		23b DATE 4-11-69		23c NAME OF CEMETERY OR CREMATORY EPWORTH CH. COM.		23d. LOCATION (City or Town) (County) (State) LAUREL SUSSEX Del			
24 FUNERAL DIRECTOR Harold Harrison				ADDRESS Laurel Del		25a. REC'D BY REGISTRAR APR 16 1969		25b REGISTRAR'S SIGNATURE Charles J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06155		CERTIFICATE OF DEATH						06151	
1. DECEASED NAME (Type or print)					First Middle Last		2a. DATE OF DEATH		2b. HOUR
JOSEPH ELTON SAVAGE							April 21, 1969		5:55 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		MAY 24, 1897		71 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MARYLAND		U.S.A.				WICOMICO			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury			Deer's Head State Hospital			ENGINEER		ICE PLANT	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. CITY OR TOWN		13c. INS DE CITY LIM TST YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Worcester Ocean City				Rt. #1		
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last				
HARPER SAVAGE					LOA SELBY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)					16b. SOCIAL SECURITY NO		17. INFORMANT Address		
YES					218-10-4448A		MRS JOYCE ZULLON OCEAN CITY, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of right lung with wide spread metastasis									1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (this hospital) attended the deceased from June 19, 1968, to April 21, 1969, that (A) (we) last saw the deceased alive on April 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A. C. Mitchell					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/22/69		
22d. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.					22e. ADDRESS Deer's Head State Hospital, Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/21/69		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL		23d. LOCATION (City or Town) (County) (State) BERUN WOR MD			
24. FUNERAL DIRECTOR Anna A. Brubage Berlin Md		ADDRESS		25a. REC'D BY REGISTRAR APR 25 1969		25b. REGISTRAR'S SIGNATURE Charles George			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1-1-69

06156		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06152	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print) Raymond		First Raymond		Middle SCHOOLFIELD		Last SCHOOLFIELD	
2a DATE OF DEATH Month APRIL Day 11 Year 1969		2b HOUR 1 A M					
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH July 2, 1893		6 AGE (in years last birthday) 75 YRS	
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Wicomico Md.	
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General		12a USLA. OCCUPATION (Kind of work done during most of working life, even if retired) Laborer		12b KIND OF BUSINESS OR INDUSTRY Lumber	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Worcester		13c CITY OR TOWN Pocomoke		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME John		First John		Middle Schoolfield		Last Schoolfield	
15 MOTHER'S MAIDEN NAME Sadie		First Sadie		Middle Johnson		Last Johnson	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If unknown) (If yes give war or dates of service) No		16b SOCIAL SECURITY NO. 179-12-2583A		17 INFORMANT Emma Schoolfield		Address Pocomoke, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis							
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Nervous System Lesion							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-6- , 19 69 , to 4-11 , 19 69 , that (I) (we) last saw the deceased alive on 4-10 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James H. Coffey M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-11-69	
22d. PHYSICIAN'S NAME (Type) James H. Coffey				22e. ADDRESS Medical Center Salisbury Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-15-69		23c. NAME OF CEMETERY OR CREMATORY St. James Cem.		23d. LOCATION (City or Town) (County) (State) Pocomoke Worcester Md.	
24. FUNERAL DIRECTOR James H. Coffey				ADDRESS New Church Va.		25a. REC'D BY REG. STRAR APR 16 1969	
						25b. REGISTRAR'S SIGNATURE Charles Judge	

06157

CERTIFICATE OF DEATH

06153

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
WALTER SCOTT SHEPPARD						Month	Day	Year	1:50 M	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	White		9-12-1880			88		MONTHS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Wicomico				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury			Peninsula General Hospital			Grocery Supplies			Wholesales	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	3d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Wicomico		Salisbury	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		321 Park Ave.,		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Last
William			E.		Sheppard	Ella				Smith
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			214-10-7312		Miss. Nellie Sheppard, See Sec #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u>										24 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										years
(b) <u>arteriosclerotic heart disease</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work						Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>4-22</u> , 19 <u>69</u> , to <u>4-22</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED		
<u>John T. Bulkeley</u>								4-23-1969		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
Dr. John T. Bulkeley						Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			4-24-1969		Parsons Cemetery			Salisbury, Maryland		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hill Funeral Home Salisbury, Maryland						DATE APR 28 1969		<u>John T. Bulkeley</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06158

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06154

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
ERNEST EDWARD SMOCKLEY						Month Day Year			1:50 AM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
M	W	Sept. 27 1891	77 YRS	MONTHS	DAYS	HOURS	MIN.	Month Day Year	2:10 AM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Wicomico Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital			Salesman, Ret.			Whlase		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Wicomico		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		813 Smith St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
John W. Shockley			Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT						
no			Yes-Unknown		Robert E. Shockley						
					ADDRESS Loblolly Lane Salisbury						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u>											<u>hours</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCU</u>											<u>years</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			Camden Ave. Salisbury			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			4-4-69		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial			4/7/1969		Wicomico Memorial Park		Salisbury		Wico.		Md.
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hill Funeral Home						Salisbury		APR. 8 1969		Charles Judge	

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06159

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06155

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Luther		(None)		Shores	ESTIMATED		4	27	69	11:55 P
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		Month	Day	Year
Male	White	Aug. 15, 1885	33 YRS			4		27	69	11:55 P
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED		NEVER MARRIED	9. COUNTY OF DEATH					
Md.	USA	WIDOWED		DIVORCED	Wicomico		Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury		Peninsula Gen. Hosp.		Waterman		Fishing				
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
Md.		Wicomico	Salisbury	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	631 E. Church Street					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Humphrey				Shores	Mary				Watson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS				
no				Mrs. Minnie Shores		Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u>										days
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>Fractured left hip</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?						
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. P.M. 4-12-69		Fell at home.						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
		own home		631 E. Church St.,		Salisbury,		Wic.,		Md.
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED
<u>Earl L. Royer</u>		409 Camden Ave.,		Salisbury, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				April 28, 1969
ADDRESS (Street, city, town, or county)		23a. BURIAL, CREMATION, REMOVA. (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)
		Burial		April, 1969		Shores Cemetery		James Quarter,		Somerset, Md
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE				
Thomas F. Wallace				APR 30 1969		<u>Charles Judge</u>				
Thomas F. Wallace, Salisbury, Md.										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First <i>Lillian</i>		Middle <i>W.</i>		Last <i>Short</i>		2a. DATE OF DEATH Month <i>4</i> Day <i>16</i> Year <i>69</i>			2b. HOUR <i>7:45</i> AM	
3. SEX <i>Female</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH <i>7-15-74</i>			6. AGE (In years last birthday) <i>94</i> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Wicomico</i>			Md			
10. CITY OR TOWN OF DEATH <i>Salisbury</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wicomico Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>none</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>---</i>				
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <i>md</i>			13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Salisbury</i>		13d. INSIDE CITY LIM TSY YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1014 Camden Avenue</i>				
14. FATHER'S NAME First <i>J.S.P.</i> Middle _____ Last <i>White</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Emma</i> Last <i>Truitt</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>218-48-6075</i>		17. INFORMANT (Niece) Address <i>Mrs. Clara P. Lankford, Woodstown, N. J.</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <i>Cardiac failure</i>													
DUE TO, OR AS A CONSEQUENCE OF													
(b) <i>Arteriosclerosis</i>													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
<i>Ulcerative colitis</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. ALTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____							
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 5, 1968</i> to <i>April 16, 1969</i> , that (I) (we) last saw the deceased alive on <i>4-15</i> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>Frank J. Weaver</i> MD DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>4-16-69</i>				
22d. PHYSICIAN'S NAME (Type) <i>Dr. Frank Weaver</i>						22e. ADDRESS <i>Salisbury, Maryland</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>April 18, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parsons Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Salisbury, Wicomico, Maryland</i>					
24. FUNERAL DIRECTOR ADDRESS <i>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</i>						25a. REC'D BY REGISTRAR DATE <i>APR 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 45M
45M

06161										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06157																			
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																			
MINNIE										SLADE										April 15, 1969										7:20AM									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR					IF UNDER 24 HRS														
Female					Colored					July 28, 1887					81 YRS.					MONTHS					DAYS														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH										Md														
Virginia					USA										WICOMICO																								
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY																								
Salisbury					Deer's Head State Hospital					Housework					home																								
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER																			
Maryland					Caroline					Federalsburg										207 Brooklyn Avenue																			
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																													
George Sheppard										Emily Stratton																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT Address																			
No										Unknown										Emma Giddins, Bird's Nest, Virginia																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																								
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident with right hemiplegia & aphasia															3 months																								
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis															Years																								
DUE TO, OR AS A CONSEQUENCE OF (c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																							
Bilateral cataracts																																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (A) (this hospital) attended the deceased from January 28, 1969, to April 15, 1969, that (A) (we) last saw the deceased alive on April 15, 1969, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE										DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED																			
A. C. Mitchell, M. D.																				4/15/69																			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																													
A. C. Mitchell, M. D.										Deer's Head State Hospital, Salisbury,																													
23a. BURIAL, CREMATION, REMOVAL (Type)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)																								
Burial					April 19, 1969					Mt. Zion Church Cemetery					Bethlehem, Maryland																								
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																			
Frampton Funeral Home, Federalsburg, Maryland										APR 30 1969										Charles Judge																			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parenthesis in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06162

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06158

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
EDWARD HARVEY SMITH						2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (in years last birthday)			7. IF UNDER 1 YEAR		
Male			White			March 19, 1917			52 YRS			MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH					
Pennsylvania			USA			WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			WICOMICO					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury			Peninsula General Hospital			Laborer - Attendant			Serv. Station					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Maryland			Wicomico			Salisbury			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			810 E. Church Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT (Wife)		
R. Van Smith			Ida Gertrude Prettyman			Yes			220-10-9972			Mrs. Kathleen M. Smith, Salisbury, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Fractured cervical spine</u>												sudden		
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						21b. TIME OF INJURY Month, Day, Year						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)		
						9 HOUR P.M. 4-14-69						Pedestrian struck by automobile.		
21d. INJURY OCCURRED						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No City or Town County		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						street						Snow Hill Rd. & Locust St., Salisbury, Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						April 17 /1969		
Earl L. Royer, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
409 Camden Ave., Salisbury, Maryland						ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)				
Burial				April 17, 1969		Wicomico Memorial Park				Salisbury, Wicomico, Maryland				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE		
HOLLOWAY & COMPANY, SALISBURY, MARYLAND						DATE APR 18 1969						K. L. Jones		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

06163

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06159

1 DECEASED-NAME (Type or Print) First Middle Last Alice Perdue Stephens			2a DATE KNOWN OF DEATH ESTIMATED Month Day Year 4 14 1969			2b HOUR 7 A.M.									
3 SEX F		4 RACE W		5 DATE OF BIRTH Mar. 25, 1866		6 AGE (In years last birthday) 3 YRS		7c DATE PRONOUNCED DEAD Month Day Year 4 14 1969		7d HOUR 9 A.M.					
7a BIRTHPLACE (State or foreign country) Md.			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Wicomico			Md.			
10 CITY OR TOWN OF DEATH Salisbury				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) John B. Parsons Home for Aged				12a USLA OCCUPATION (Kind of work done during most of working life, even if retired) at home				12b KIND OF BUSINESS OR INDUSTRY at home			
13a USLA RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE Md.				13b COUNTY Wicomico				13c CITY OR TOWN Parsonsborg				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME First Middle Last Samuel Parsons				15 MOTHER'S MAIDEN NAME First Middle Last Elizabeth Bond				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no							
16b SOCIAL SECURITY NO.				17. INFORMANT Records, John B. Parsons Home for Aged				ADDRESS Salisbury, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension C.V. Disease</u> 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>year</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Earl L. Royer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, P.O. box, or county) <u>Salisbury, Md.</u>				22b DATE SIGNED <u>4-14-69</u>							
23a BURIAL, CREMATION, REMOVAL <u>Buried</u>				23b DATE <u>4-16-1969</u>				23c NAME OF CEMETERY OR CREMATORY <u>Jerusalem Church Ce.</u>				23d LOCATION (City or Town) (County) (State) <u>Parsonsborg, Md.</u>			
24. FUNERAL DIRECTOR <u>Thomas F. Wallace</u>				ADDRESS <u>Salisbury, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 16 1969</u>				25b. REGISTRAR'S SIGNATURE <u>Thomas F. Wallace</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06164

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06160

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
GRANT		TYLER	STERLING		APRIL 4 1969		2:12 P.	
3 SEX	4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
Male	White		July 12, 1915		53 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		USA				Wicomico Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Salisbury		Peninsula General		Carpenter		Boat Building		
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER
Maryland		Somerset		Crisfield		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD Box 494
4. FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle
Gordon		R.	Sterling		Mary		-	Tyler
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Address		
Yes		WW 2		217-05-5047		Mrs. Garnet Ray Sterling, Same as 13. abcde		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE, BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from April 3, 1969, to April 4, 1969, that (I) (we) last saw the deceased alive on April 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.								
22b SIGNATURE Thomas C. Hill, Jr.					22c DATE SIGNED 4-4-69		22d PHYSICIAN'S NAME (Type)	
Thomas C. Hill, Jr.					22e ADDRESS Pine Bluff Road, Salisbury, Md			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		April 7, 1969		Sunnyridge Cemetery		Crisfield, Somerset, Md.		
24 FUNERAL DIRECTOR ADDRESS					25a BY REG. STRAR DATE		25b REGISTRAR'S SIGNATURE	
Bradshaw & Sons, Crisfield, Md. 21817					APR 8 1969		Michael Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

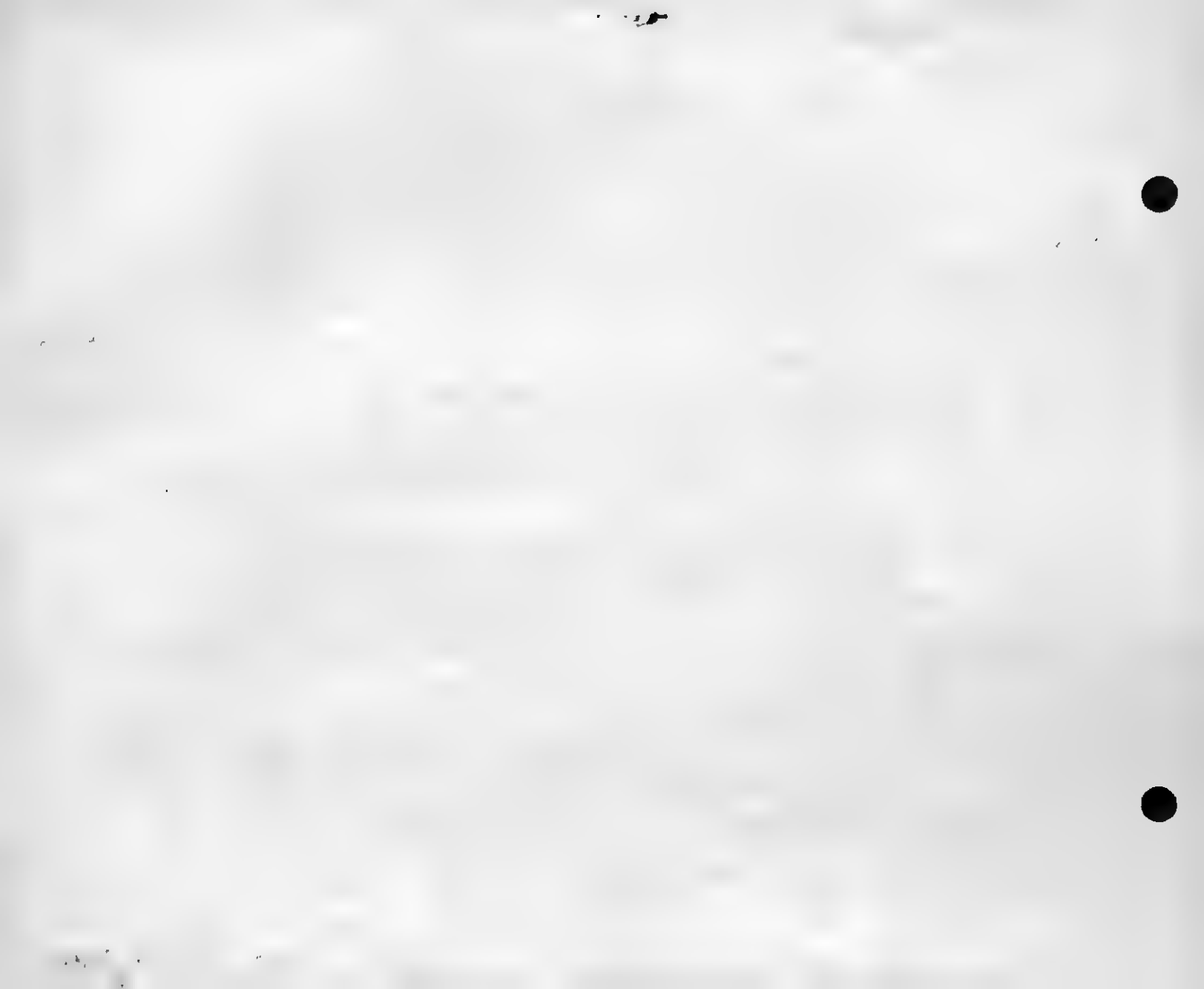
VR 4-15
MSM 1-1-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
06165 CERTIFICATE OF DEATH 06161																	
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR						
JESSIE			ESTA		TAYLOR				April 30 1969		8:55 PM						
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Female			White			August 1, 1903			65 YRS.								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
Maryland			USA						WICOMICO					Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY								
Salisbury			Peninsula General Hospital			Retired Saleslady			Dept. Store								
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER					
Maryland			Wicomico			Salisbury			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			208 Saratoga Street					
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First		Middle		Last	
Laird							Davis		Georgia							Horner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT (Husband)			Address								
No			(If yes give war or dates of service)			214-10-8985A			Mr. Harold W. Taylor, Salisbury, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>anemia - hydrocephalus.</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No			City or Town			County			State		
22a. I certify that (I) (this hospital) attended the deceased from <u>4/15</u> , 19 <u>60</u> to <u>4/30</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/30</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																	
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
<u>Dr. E. M. Beardsley</u>			May 2 / 1969			Dr. E. M. Beardsley			Maryland Avenue, Salisbury, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)								
Burial			May 3, 1969			Wicomico Memorial Park			Salisbury, Wicomico, Maryland								
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
HOLLOWAY & COMPANY, SALISBURY, MARYLAND						MAY 7 1969			Charles Judge								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the coroner's paper, pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
OSCAR CLEVELAND TAYLOR						Month Day Year April 1 1969			10:40 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		September 30, 1889		83 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		USA				WICOMICO Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury			Peninsula General Hospital			Cabinet maker		Lumber Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INS. OF CITY, LIM. TS?		13e. STREET AND NUMBER
Maryland			Wicomico		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		419 Pine Bluff Road
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last Emerson Scott Taylor			First Middle Last Frances Bartterson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown			16b. SOCIAL SECURITY NO		17. INFORMANT (Wife) Address				
No			189-05-3568		Mrs. Helen W. Taylor, Salisbury, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>									19 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Previous CVA, & Cerebral Arteriosclerosis</u>									
(c) <u>Sclerosis of heart</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				Street or R.F.D. No					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/13/69</u> to <u>4/1/69</u> that (I) (we) lost sight of the deceased alive on <u>4/1/69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED
<u>Dr. O. J. Burton</u>									April 2 / 1969
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
					Salisbury, Maryland				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(Co.nty)	(State)
Burial		April 3, 1969		Wicomico Memorial Park		Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REG STRAR		25b. REG STRAR'S SIGNATURE
HOLLOWAY & COMPANY, SALISBURY, MARYLAND							DATE APR 7 1969		<u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06167									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) Della F. TERRY			2a. DATE OF DEATH Month APRIL Day 19 Year 1969			2b. HOUR 7:40 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH Oct. 31, 1913		6 AGE (In years last birthday) 25 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) W.D.		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico			
10 CITY OR TOWN OF DEATH Salisbury W.D.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Salisbury General Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY Self			
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE N.J.		13b COUNTY Clatsop		13c CITY OR TOWN Oregon		13d INS OF CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER	
14. FATHER'S NAME John F. Terry			15. MOTHER'S MAIDEN NAME Jessie Southwick			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No			
16b. SOCIAL SECURITY NO. None			17 INFORMANT Frank Jones - Salisbury N.J.			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS. 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 5-3-65		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA PANCREAS.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5-3-65 , 19 65 , to 4-19 , 19 69 , that (I) (we) last saw the deceased alive on 4-18 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Frank Jones		22c. DATE SIGNED 19 APR - 69		22d. PHYSICIAN'S NAME (Type) Frank Jones		22e. ADDRESS Salisbury N.J.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE 4/13/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Green Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury N.J.			
24. FUNERAL DIRECTOR General Jones - Salisbury, Del.		25a. REC'D BY REGISTRAR DATE APR 23 1969		25b. REGISTRAR'S SIGNATURE General Jones					



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1

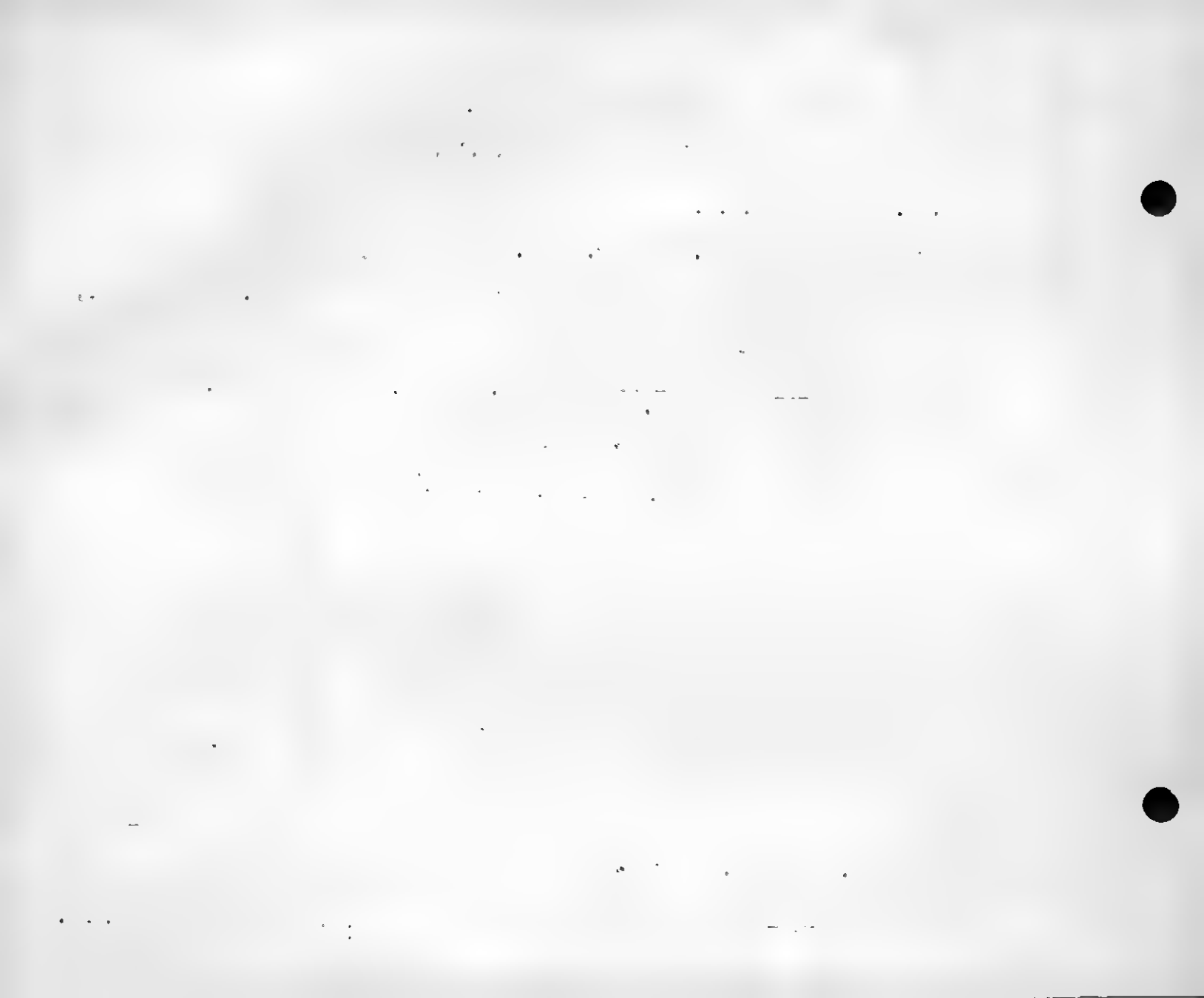
06168

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06164

1. DECEASED NAME (Type or print) Virginia Henderson Thomas			2a. DATE OF DEATH Month 4 Day 18 Year 1969		2b. HOUR M
3 SEX Female	4. RACE White	5. DATE OF BIRTH Oct. 12, 1882		6 AGE (in years last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) W. Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Wicomico Md.		
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sp. Hill Pr. Sana.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) house wife		12b. KIND OF BUSINESS OR IND. STRY Own Home
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY, LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 112 E. Isabella St.,	
14. FATHER'S NAME First Henry Middle Clay Last Henderson		15. MOTHER'S MAIDEN NAME First Caroline Middle Snodgrass Last Snodgrass			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 220-01-8858	17 INFORMANT Address Mrs. John Langelier, See Sec. #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Purulent arterio sclerosis DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1969 to April 16, 1969 , that (I) (we) last saw the deceased alive on 4-13-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Philip A. Insley		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 4-17-1969	
22d. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley MD		22e. ADDRESS Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-18-1969	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico. Md.	
24. FUNERAL DIRECTOR Hill Funeral Home		ADDRESS Salisbury, Maryland		25a. REC'D BY REGISTRAR APR 21 1969 DATE	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
06169 Items 5&6 Film 412 5/7/69 kk																
06165																
1. DECEASED NAME (Type or print)			First GEORGIA			Middle ANNA			Last TILGHMAN			2a. DATE OF DEATH Month Day Year April 19, 1969			2b. HOUR 2:00A M	
3 SEX Female			4 RACE Colored			5. DATE OF BIRTH 4/12/1890			6 AGE (In years last birthday) 79 YRS.			7 UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) South Carolina			7b. CITIZEN OF WHAT COUNTRY? U S A			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH WICOMICO			Md.				
10 CITY OR TOWN OF DEATH Salisbury			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deer's Head State Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic			12b KIND OF BUSINESS OR INDUSTRY Cook							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Somerset			13c CITY OR TOWN Princess Anne			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER				
14. FATHER'S NAME			First ?			Middle ?			Last ?			15. MOTHER'S MAIDEN NAME First Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17 INFORMANT Mrs Cathrine Smith, Venton, Maryland			Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Recurrent cerebral thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Years</u>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State										
22a. I certify that (this hospital) attended the deceased from <u>September 23, 1968</u> , to <u>April 19, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 19, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (dd) (RR) view the body after death.																
22b. SIGNATURE <u>L. V. Maldve</u>			22c. DATE SIGNED 4/21/69			22d. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.			22e. ADDRESS Deer's Head State Hospital, Salisbury,							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/22/69			23c. NAME OF CEMETERY OR CREMATORY Grace			23d. LOCATION (City or Town) (County) (State) Venton, Maryland							
24. FUNERAL DIRECTOR William H. James Jr Princess Anne, Md			25a. REC'D BY REGISTRAR DATE APR 28 1969			25b. REGISTRAR'S SIGNATURE Charles Judge										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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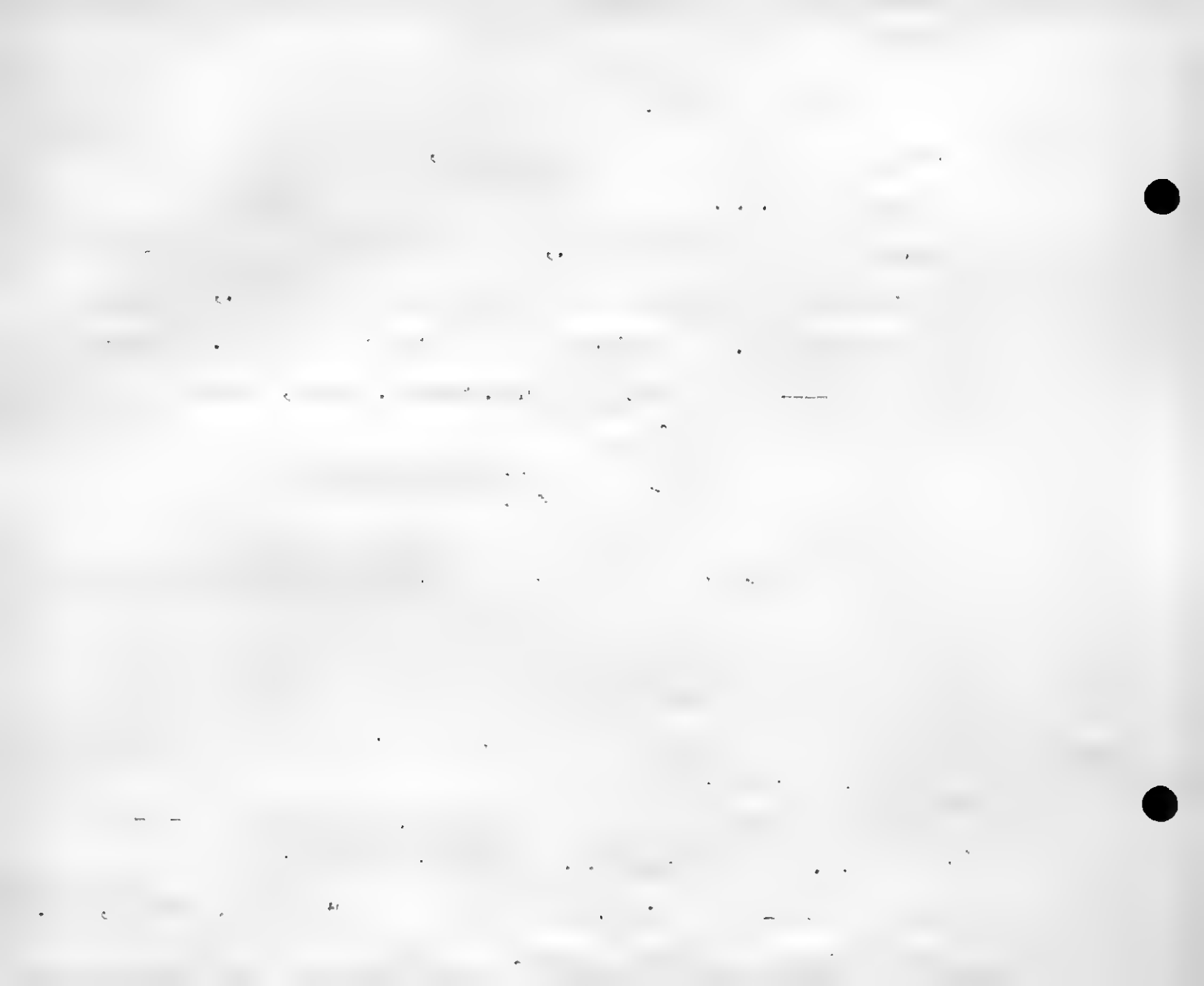
VR A15 (4)
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
06170									
06166									
1 DECEASED NAME (Type or print)			First <i>Rocelia</i> Middle <i>Timmons</i> Last			2a. DATE OF DEATH Month <i>APRIL</i> Day <i>3</i> Year <i>1969</i>			2b. HOUR <i>1450</i> M
3 SEX <i>Female</i>	4 RACE <i>Negro</i>		5. DATE OF BIRTH <i>6-10-33</i>			6 AGE (In years last birthday) <i>35</i> YRS		IF UNDER MONTHS	IF UNDER 24 HRS DAYS
7a. BIRTHPLACE (State or foreign country) <i>Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <i>Wicomico</i>			Md
10. CITY OR TOWN OF DEATH <i>Salisbury</i>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Peninsula General</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Caterer</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before death) STATE <i>Maryland</i>			13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Willards</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Rt # 50</i>
14. FATHER'S NAME First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i>			15. MOTHER'S MAIDEN NAME First <i>Jebbie</i> Middle <i>Fields</i> Last <i>Fields</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO <i>214-32-6551</i>		17 INFORMANT <i>Robert Earl Timmons</i> Address <i>2145 Plover Salisbury, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Vascular Disease</i>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<i>Diabetes with Acidosis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>April 2, 1969</i> , to <i>April 3, 1969</i> , that (I) (we) last saw the deceased alive on <i>April 3, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Thomas C. Hiep Jr. M.D.</i>				22c. ADDRESS <i>Pine Bluff Road, Salisbury, Md.</i>		22d. DATE SIGNED <i>4-3-69</i>			
22e. PHYSICIAN'S NAME (Type)									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>4-7-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Jerusalem</i>		23d. LOCATION (City or Town) (County) (State) <i>Temperanceville Acc. Va.</i>			
24. FUNERAL DIRECTOR <i>Loretta B. Jolley</i>		ADDRESS <i>Salisbury, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR P
MAURICE THOMAS TRUITT						Month	Day	Year	1:20 M
3 SEX	4. RACE		5. DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN.
Male	White		March 3, 1893			76 YRS.			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			
Maryland	U.S.A.					Wicomico Md.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Pittsville			Pine St.,			Retired		Postmaster	
13a USUAL RESIDENCE (Where deceased lived, if in institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER		
Maryland			Wicomico		Pittsville		Pine St.,		
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Thomas H. Truitt						Sarah R. Williams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17 INFORMANT Address			
No			None			Mrs. Hazel D. Truitt, Sec 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Culmia</i>									<i>3 wks.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic pyelonephritis</i>									<i>5 yrs.</i>
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Congestive heart failure - arterio-sclerotic heart disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug. 1968</i> to <i>4/18, 1969</i> , that (I) (we) last saw the deceased alive on <i>4/18, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Earl Beardsley</i>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 4-29-1969		
22d PHYSICIAN'S NAME (Type) Dr. Earl Beardsley M.D.					22e ADDRESS Salisbury, Maryland				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4-30-1969		Pittsville, Cemetery		Pittsville, Wicomico, Maryland			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hill Funeral Home Salisbury, Maryland					MAY 1 1969		<i>Charles J. Jones</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06172

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06168

1. DECEASED NAME (Type or print) First Middle Last JOHN WESLEY VENABLE			2a. DATE OF DEATH Month Day Year April 15 1969		2b. HOUR 9:25 AM
3. SEX MALE	4. RACE White	5. DATE OF BIRTH March 6, 1875		6. AGE (In years last birthday) 94 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WICOMICO Md		
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address) Peninsula Gen. Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Blacksmith		12b. KIND OF BUSINESS OR INDUSTRY Foundry	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland	13b. COUNTY Worcester	13c. CITY OR TOWN Pocomoke	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 724 Clarke Avenue	
14. FATHER'S NAME First Middle Last Thomas -- Venable	15. MOTHER'S MAIDEN NAME First Middle Last -- unknown --				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No --	16b. SOCIAL SECURITY NO 219-14-4711	17. INFORMANT Address J. Richard Venable, Pocomoke City, Md.			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Car Cancer 157.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Aut. Pancreas					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Arteriosclerotic CN. disease					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/8/69, 1969, to 4/15/69, 1969, that (I) (we) lost the deceased alive on 4/15/69, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 4/23/69		
22d. PHYSICIAN'S NAME (Type) Oswald J. Burton, M.D.		22e. ADDRESS Medical Center, Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-18-1969	23c. NAME OF CEMETERY OR REMOVAL ADDRESS Salem Methodist	23d. LOCATION (City or Town) (County) (State) Pocomoke City-Wor.-Md.		
24. FUNERAL DIRECTOR Robert H. Watson		25a. REC'D BY REGISTRAR Robert H. Watson Pocomoke City, Md.		25b. REGISTRAR'S SIGNATURE [Signature]	DATE R 25 1969

VR A15
45M

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06173

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06169

1 DECEASED-NAME (Type or Print)			First CHARLES			Middle VINSON, JR.			Last			2a DATE KNOWN OF DEATH Month Day Year 4-17-69 19			2b HOUR 9:40 A								
3 SEX Male		4 RACE AA		5 DATE OF BIRTH 8-19-52		6 AGE (in years last birthday) 16 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PROUNCEDEAD Month Day Year 4 17 1969			2d HOUR 9:40 A								
7a BIRTHPLACE (State or foreign country) Maryland				7b CITIZEN OF WHAT COUNTRY? U S A				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH Wicomico Md											
10 CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY											
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b COUNTY Somerset				13c CITY OR TOWN Princess Anne				13d INSIDE CITY LIMITS? NO <input type="checkbox"/>		13e STREET AND NUMBER Route 1, Box 57A									
14. FATHER'S NAME Charles						15. MOTHER'S MAIDEN NAME Lorlane McKinney																	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b SOCIAL SECURITY NO.						17 INFORMANT Charles Vinson						ADDRESS Princess Anne, Maryland					
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 9229 DUE TO, OR AS A CONSEQUENCE OF Shotgun wound of right chest and abdomen minutes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
2a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year 9 HOUR A.M. 4-17-69						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Accidentally shot by brother, age 14.											
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) own home						21f. LOCATION Street or R.F.D. No. City or Town County State Route 1, Princess Anne, Somerset, Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Earl L. Royer, M.D. 409 Camden Ave., Salisbury, Md.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22b DATE SIGNED April 17, 1969											
23a BURIAL, CREMATION, REMOVAL (Specify) Burial						23b DATE 4/20/69						23c NAME OF CEMETERY OR CREMATORY Mt Calvary						23d LOCATION (City or Town) (County) (State) Fruitland Maryland					
24 FUNERAL DIRECTOR'S NAME (Type) Joby James												25a REC'D BY REGISTRAR DATE APR 22 1969						25b REGISTRAR'S SIGNATURE Charles J. Jones					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06174		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06170	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR
Shadys		S.		Voyce	April 19 69		2:39 AM
3 SEX	RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
F	W		MAR. 28 1903		66 YRS		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
PITTSBURGH PA		U.S.A.				WICOMICO Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
SALISBURY		GEN. HOSPITAL		MUSIC TEACHER		U.S.A.	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS. OR CITY, LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		WOR.		BERLIN		BURLY ST	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First Middle Last
WILLIAM SCHOBERTH					ANNA (2)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address	
NO		216-14-7687		MRS MILDRED DECKMAN		FT. LAUDERDALE FLA.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 2050 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months (by history)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC		21f. LOCATION Street or R.A.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/16/69, to 4/19/69, that (I) (we) last saw the deceased alive on 4/18/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMQVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		4/22/69		EVERGREEN		BERLIN WOR MD.	
24 FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Anna A. Burbage		Berlin Md.		APR 25 1969		W. C. ... Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

06175 Item 23 Film G12 5/6/69 kk		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		06171	
1 DECEASED NAME (Type or print) <u>First</u> <u>Mattie Ruth</u> <u>Middle</u> <u>WALLER</u> <u>Last</u>				2a. DATE OF DEATH <u>April</u> <u>29</u> <u>1969</u> 2b. HOUR <u>4A</u> <u>M</u>	
3 SEX <u>Female</u>		4 RACE <u>Cal</u>		5 DATE OF BIRTH <u>Jan</u> <u>04</u>	
7a. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH <u>Schlesburg</u>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Gen Sen Hosp</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>domestic</u>	
13a. USUAL RESIDENCE (where deceased lived, if institution Residence before admission) STATE <u>Wisconsin</u>		13b. COUNTY <u>Sauk</u>		13c. STREET AND NUMBER <u>417 Rose St</u>	
14 FATHER'S NAME <u>John</u> <u>Lewis</u>		15 MOTHER'S MAIDEN NAME <u>Mamie</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16b. SOCIAL SECURITY NO. <u>280</u>		17 INFORMANT <u>James Waller</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4122</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. Disease 5 yrs</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or RFD No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/20 1969</u> to <u>4/29 1969</u> , that (I) (we) last saw the deceased alive on <u>4/29 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <u>M B Smith</u>		DEGREE <u>MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22a. PHYSICIAN'S NAME (Type)		22b. ADDRESS		22c. DATE SIGNED <u>4/29/69</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>5/21 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Repos Hill Cem</u>	
24. FUNERAL DIRECTOR <u>Frank J. Miller</u>		ADDRESS		23d. LOCATION (City or Town) (County) (State) <u>Johnsonville Wis</u>	
25a. REC'D BY REGISTRAR <u>May</u>		DATE <u>1 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William Cudde</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
SARAH ELIZABETH WALLER						Month Day Year April 8 1969		5:15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
Female		White		July 12, 1924		44 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		USA				WICOMICO			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital		Housewife		---			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Res. dence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. NO. OF CITY INHABITANTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Wicomico		Salisbury				510 Washington Street	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Alonza A. Larmore						Ella Thomas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT (husband) Address				
no			216-16-7162		Mr. Horace E. Waller, Salisbury, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>492X Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>COP pulmonary</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>pulmonary embolism</i>								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <i>1 wk</i> <i>yes</i> <i>yes</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 15</i> to <i>48</i> 1969, that (I) (we) last saw the deceased alive on <i>4/5</i> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>E. M. Beardsley</i>		22c. DATE SIGNED April 9 / 1969					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Dr. E. M. Beardsley		Salisbury, Maryland							
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 11, 1969		Wicomico Memorial Park		Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR ADDRESS				25a. REGD BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
HOLLOWAY & COMPANY, SALISBURY, MARYLAND				APR 11 1969		<i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06177										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06173									
1. DECEASED NAME (Type or print)										20. DATE OF DEATH										2b. HOUR									
NANCY HELEN WALLEY										April 15, 1969										12:55 PM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS														
Female			Colored			8-19-1891			77 YRS			MONTHS DAYS HOURS MIN			HOURS MIN														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
MARYLAND			USA						WICOMICO						Md														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Salisbury			Deer's Head State Hospital																										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
Maryland			Talbot			Easton			YES <input type="checkbox"/> NO <input type="checkbox"/>			Rt. #2, Box 147																	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																										
JAMES			SKINNER			CARRIE			THOMAS																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address																				
No			220-017429			Percy Walley																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, Right Lung</u>										2 days																			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Thrombosis Due to Arteriosclerosis</u>										8 months																			
DUE TO, OR AS A CONSEQUENCE OF (c) _____																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No City or Town County State																							
22a. I certify that (A) (this hospital) attended the deceased from <u>October 28, 1968</u> to <u>April 15, 1969</u> , that (A) (we) last saw the deceased alive on <u>April 15, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS																				
L. V. Maldve, M. D.			4/15/69			L. V. Maldve, M. D.			Deer's Head State Hospital, Salisbury,																				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)																				
BURIAL			4-19-69			RICHARDS			EASTON TALBOT MD.																				
24. FUNERAL DIRECTOR: J B DASHIELL FUNERAL HOME ADDRESS 426 DOVER										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Barbara L. Dashiell - EASTON, MD. 21601										APR 18 1969										J Charles Judge									

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
06178		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						06174					
1. DECEASED-NAME (Type or Print)					2. DATE KNOWN OF DEATH					2b. HOUR			
First Middle Last JAMES WEST					Month Day Year 4-18-69					9 A			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			
Male		AA		12-26-10		58 YRS		MONTHS DAYS HOURS MIN		Month Day Year 4 18 69			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Alle			U.S.A.						Wicomico Md.				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury				Peninsula General									
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.				Wicomico		Salisbury				Rt. 2, Purnell St.			
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last								
Unknown					Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
W.W.H.							Eddie Lee West						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion										sudden			
4109 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22b. DATE SIGNED			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					April 21, 1969			
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVA (Specify)					23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial					4-26-69		Robertson St Cem		Salisbury Wicomico				
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Booker West Funeral Home, Salisbury, Md.							APR 24 1969		W. Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06179

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06175

1 DECEASED NAME (Type or print) CARRIE E WHITE			2a. DATE OF DEATH Month APRIL Day 23 Year 1969			2b. HOUR 4:00 M	
3 SEX FEMALE		4 RACE COLORED		5 DATE OF BIRTH MARCH 7, 1900		6 AGE (n years lost birthday) 69 YRS	
7a. BIRTHPLACE (State or foreign country) DAMES QUARTER MD.		7b. CIT ZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WICOMICO Md	
10 CITY OR TOWN OF DEATH SALISBURY		NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) PENINSULA GEN. HOUSE WIFE		12a. U.S. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) MARYLAND STATE		13b. COUNTY SOMERSET		13c. CITY OR TOWN DAMES QUARTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER							
14 FATHER'S NAME First CLINTON Middle WIGFALL Last SALLIE			15 MOTHER'S MAIDEN NAME First SALLIE Middle ROBERTS Last ROBERTS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (or unknown)		16b. SOCIAL SECURITY NO 219-05-3502		17 INFORMANT Ralph White		Address Dames Quarter, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 205X DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Myeloma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus with Acidosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from April 18, 1969 to April 23, 1969 , that (I) (we) lost saw the deceased alive on April 23, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas C. Kelly, MD		22c. DATE SIGNED 4-24-69		22d. PHYSICIAN'S NAME (Type) PINE BLUFF RD, SALISBURY, MD		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/26/69		23c. NAME OF CEMETERY OR CREMATORY MACEDONIA		23d. LOCATION (City or Town) (County) (State) DAMES QUARTER SOMERSET, MD	
24. FUNERAL DIRECTOR William J. James III		25a. REC'D BY REGISTRAR APR 29 1969		25b. REGISTRAR'S SIGNATURE William J. James III			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06180		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06176	
1 DECEASED NAME (Type or print) First Middle Last EMILY G. WILLIAMS			2a. DATE OF DEATH Month Day Year APRIL 12 1969			2b. HOUR 9:45 AM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH JUNE 10, 1901		6 AGE (In years last birthday) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) BERN MIP		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md	
10 CITY OR TOWN OF DEATH SALISBURY		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PEN. GEN. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUA. RES. DENCE (Where deceased lived, if institution Res. dence before admission) STATE MARYLAND		13b. COUNTY WICOMICO		13c. CITY OR TOWN BERN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER BAY ST		14 FATHER'S NAME First Middle Last FRANK FISHER		15 MOTHER'S MAIDEN NAME First Middle Last MARGARET QUILLEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give unit or dates of service) No		16b. SOCIAL SECURITY NO. No		17 INFORMANT Address MR. ARMON R. WILLIAMS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <u>unknown</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-18</u> , 19 <u>69</u> , to <u>4-12</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-12</u> , 19 <u>69</u> (and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Wilbur Ellis</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>4-12-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>Wilbur Ellis</u>				22e. ADDRESS <u>MEDICAL CENTER Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>4/15/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City or Town) (County) (State) <u>BERN MIP MD</u>	
24. FUNERAL DIRECTOR <u>Anna A. Burbage</u>				ADDRESS <u>Berlin Md</u>		25. ISSUED BY REGISTRAR <u>APR 17 1969</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and regularly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06181

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06177

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
ISAAC			SAMUEL	WILLIAMS	April 26 1969			M			
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		April 22, 1885		84 YRS.		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md		
Maryland		USA				WICOMICO					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Salisbury			2707 Ocean City Road			Retired Farmer			Farming		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Maryland			Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		2707 Ocean City Road		
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last		
Isaac			Samuel	Williams	Fannie Martha Jones						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.		17 INFORMANT(Son)			Address			
No			220-28-0956		Mr. Preston C. Williams, Salisbury, Maryland						
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral artery thrombosis										2 min.	
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f LOCATION		Street or R.F.D. No		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 10-5, 1968, to 4-26, 1969, that (I) (we) last saw the deceased alive on 4-17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE						22c DATE SIGNED					
Dr. Frank Weaver						April 28 / 1969					
22d. PHYSICIAN'S NAME (Type)						22e ADDRESS					
Dr. Frank Weaver						Salisbury, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			April 29, 1969		Wicomico Memorial Park			Salisbury, Wicomico, Maryland			
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HOLLOWAY & COMPANY, SALISBURY, MARYLAND						APR 30 1969		Charles Jones			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon number 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury,		c. LENGTH OF STAY IN lb 4 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springhill Sanitarium, Inc		d. STREET ADDRESS BERLIN. Baker St	
3. NAME OF DECEASED (Type or print) Dora E. Wise		4. DATE OF DEATH Month April Day 15 Year 1969	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-1878
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKKEEPER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (County & State, or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willis Wise		14. MOTHER'S MAIDEN NAME GEORGIANA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year and dates of service) NO		16. SOCIAL SECURITY NO. 217-03-5972A	
17. INFORMANT MRS MURRAY OLTMAN		Address BERLIN MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4122 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Cardiovascular renal disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec , 1968, to 4-15 , 1969, that (I) (we) last saw the deceased alive on 4-14 , 1969, and that death occurred at 5 P M, from causes and on the date stated above.			
22a. SIGNATURE Philip A. Insley		22b. DATE SIGNED 4-16-69	
22c. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley		22d. ADDRESS 116 E. Main St. Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/17/69	23c. NAME OF CEMETERY OR CREMATORY EVERGREEN	23d. LOCATION (City or Town) (County) (State) BERLIN WOR. MD
24. FUNERAL DIRECTOR Anna A. Burbage		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE APR 18 1969	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
06183		06179									
1. DECEASED-NAME (Type or print) HERBERT THOMAS WISE						2a. DATE OF DEATH Month April Day 16 Year 1969			2b. HOUR 8:50 AM		
3. SEX Male		4. RACE Colored		5. DATE OF BIRTH May 11, 1911			6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md.					
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deer's Head State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Auto Body Worker			12b. KIND OF BUSINESS OR INDUSTRY Automobile		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Caroline		13c. CITY OR TOWN Preston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD #2, Box 86C		
14. FATHER'S NAME First Unknown Middle Unknown Last Unknown				15. MOTHER'S MAIDEN NAME First Sina Middle Wise Last Wise							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 231-12-3593		17. INFORMANT Address Roberta Wise, Preston, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1621 IMMEDIATE CAUSE (a) Carcinoma of the right lung - terminal DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from April 16, 1969 to April 16, 1969 , that (X) (we) last saw the deceased alive on April 16, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C. H. Winnacott, M. D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/16/69			
22d. PHYSICIAN'S NAME (Type) C. H. Winnacott, M. D.		22e. ADDRESS Deer's Head State Hospital, Salisbury, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE April 19, 1969		23c. NAME OF CEMETERY OR CREMATORY Jonestown Cemetery			23d. LOCATION (City or Town) (County) (State) Near Preston, Maryland				
24. FUNERAL DIRECTOR J. J. Hampton & Son Federalburg, Md.						25a. REC'D BY REGISTRAR DATE APR 30 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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Continuation of New Right Lane - (continued)